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UNIVERSITY OF CALIFORNIA,
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Reproduction in the Welfare State:
Public Spending for Family Planning and Abortion Services in the United States

DISSERTATION

submitted in partial satisfaction of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

in Sociology

by

Mikaela H. Smith

Dissertation Committee:
Associate Professor Catherine Bolzendahl, Chair
Professor Charles Ragin
Professor Belinda Robnett
Assistant Professor Rachel Goldberg

2019

DEDICATION

This project is dedicated to:

Colby Smith, Kathy Dunn, Cartney Smith, and Jessica Banks
for their ongoing support;

and to Will Devanny
for his bad jokes and equally good brownies.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF FIGURES *Continued*

ACKNOWLEDGMENTS

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"Public Goods for Whom? The Impact of Policy Legacies on Variation in U.S.   2018
Public Spending for Reproductive Healthcare Services." Presented at the
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ABSTRACT OF THE DISSERTATION

Reproduction in the Welfare State:
Public Spending for Family Planning and Abortion Services in the United States

By

Mikaela H. Smith

Doctor of Philosophy in Sociology

University of California, Irvine, 2019

Associate Professor Catherine Bolzendahl, Chair

This project uses state-level data to answer a variety of questions related to the provision of vital healthcare services as a right of citizenship in a wealthy democracy. I focus on spending for reproductive healthcare policy specifically, which also allows me to explore the tension between state policy as granting women rights to bodily autonomy and state policy as a tool for instilling racialized and gendered norms onto women's bodies and behaviors. As such, this work as falling at the intersection of politics, health, and inequality and builds on a robust body of literature exploring variation in social protections in industrialized democracies.

In my first empirical chapter, I employ theories of welfare state development to the exploration of variation in Medicaid spending across the United States from 2006-2016. Through several time-series panel regression models, I find general support for functionalist arguments of welfare state development, though these findings are somewhat tempered by the race of those in need. My second chapter focuses on Medicaid spending for family planning services, specifically those related to contraception and sterilization. In this chapter I use OLS regression to compare state variation in spending, as derived from the Guttmacher Institute's comprehensive survey of reproductive healthcare professionals, at three recent time points. Paying particular attention to

the relationship between need for publicly supported contraceptives and spending generosity reveals that states with higher levels of need among White women tend to offer more generous spending, while those with higher need among Black women present the opposite. Similarly, my third chapter compares state policy on public spending for abortion services using two methods: traditional OLS regression and mixed-methods approach called qualitative comparative analysis (QCA).

Taken together, these three chapters support notions of a racialized and gendered welfare state in which state policy differentially mediates access to rights of citizenship. In doing so, this project offers three main contributions to the sociological literature. First, it expands upon the welfare state literature by applying traditional theories to a different form of welfare, reproductive healthcare. Second, it contributes to methodological debates surrounding best practices for small-N studies of comparative welfare states through its use of both regression and QCA. Third, it maintains the importance of applying an intersectional lens to studies of welfare state spending based on results that suggest differential policy responses depending on the race of those in need as well as via its focus on an inherently gendered form of spending, that for reproductive healthcare.

CHAPTER 1

INTRODUCTION AND THEORETICAL BACKGROUND

1 INTRODUCTION

The United States has a complicated history with provision of social services. Early

social spending came in the form of pensions for Civil War veterans, along with support for

"American women as mothers or potential mothers" (Skocpol 1992). In this way, while many

scholars tout its position as a welfare state "laggard" (e.g. De Swaan [1988]), the U.S. was

indeed an early adopter of social spending policies. Yet these social safety nets often failed to

provide equal protection across demographics, and often came with strings attached (Gordon

1994; Hacker 2002; Quadagno 1996).

In their observation of the Job Corps program of Johnson's War on Poverty, Quadagno

and Fobes find "that the welfare state reproduces gender stratification structurally by replicating

a gendered division of labor and culturally by inculcating an ideological framework that sustains

that division of labor" (Quadagno and Fobes 1995). Similarly, we can observe how racial

inequalities were perpetuated based on eligibility for this type of welfare support. The question

of the role of the state in perpetuating or alleviating inequality is not new, nor uncommon within

the sociological literature. This project simply applies this over-arching question to a single case:

reproductive healthcare in the United States.

Not unlike other types of welfare state provisions, funding and support for reproductive

healthcare services in the U.S. is extremely limited when compared to those in other

democratized, industrialized nations. Women from the U.S. report lower satisfaction with their

healthcare services while paying higher out-of-pocket costs (Gunja et al. 2018). Rates of

maternal mortality are disproportionally high, particularly for women of color (Center for Reproductive Rights 2011). The level of gender and race inequality persistent within U.S. reproductive policy and practice has suggested that the U.S. is in violation of U.N. Human Rights protocols. And yet recent policies continue to limit women's access to contraceptive and abortion services and sexual health education (Center for Reproductive Rights 2011; National Women's Law Center 2017; Sonfield 2017b, 2017a; White et al. 2015).

An exploration of the variation of spending for reproductive healthcare services in the U.S. is thus particularly timely, and important. While many reports treat the U.S. as a single case, the degree of state autonomy around legislative action, including that for publicly-funded healthcare and for protecting reproductive rights, warrants a closer state-by-state comparison. I therefore proceed with this project by investigating variation in state-level policy and spending for family planning and abortion services in the last two decades. To do so, I draw on the broader literature of the racialized and gendered welfare state. I seek to develop an understanding of the extent to which race and gender inequalities are reinforced through seemingly beneficial social spending practices.

The dissertation proceeds as follows. I continue in this introductory chapter by offering a brief history of reproductive policy in the U.S. as well as a summary of the sociological study of reproduction. This is followed by a description of the theoretical framework that I will be pursuing for this project, specifically theories of the racialized and gendered welfare state. Finally, I close by offering more detailed information about my methodological choices, namely regression and qualitative comparative analysis (QCA), and data collection process. Three empirical chapters are pursued, followed by a more general conclusion.

My first empirical chapter, Chapter 2, sets the stage for my investigation of spending for reproductive healthcare by considering how spending for Medicaid, the U.S.'s public healthcare program for citizens experiencing poverty, varies both between states and over time. Using expenditure data from the National Association of State Budget Officers, I consider how factors related to state wealth, poverty, and politics shape spending generosity. OLS and panel regression analyses are conducted on data from 2006-2016. Overall, results from this chapter offer support for the functional response of the state to poverty in shaping spending decisions. However, this response is tempered by the race of those experiencing poverty, such that we see different directions of association by between Black and White poverty levels and spending generosity. Additionally, this chapter highlights the extent to which variation does indeed exist between states, though perhaps less-so over time.

Where Chapter 2 investigates correlates of healthcare spending more broadly, Chapter 3 focuses more closely on spending for family planning services specifically. Several descriptive reports have noted how public funding for reproductive services in the United States differs both over time and between states (Frost, Frohwirth, and Purcell 2004; Hasstedt, Sonfield, and Benson Gold 2017), but few have sought to explain this variation empirically. Similarly, literature on the broader U.S. welfare state has not spent adequate time focusing on spending for reproductive healthcare, a particularly gendered and racialized social right. In this chapter, I thus explore how funding for family planning services, namely contraceptives and sterilization, vary between states between 2006 and 2015. Mimicking the analysis from Chapter 2, I proceed by exploring the extent to which functional factors that shape spending decisions are modified by the race of those in need of publicly funded contraceptives. Reproductive spending and need data come from reports by the Guttmacher Institute, an organization dedicated to researching sexual

and reproductive health both in the U.S. and internationally. Once again, findings from this chapter suggest that White women's needs more positively influence spending generosity than do Black women's needs.

My third empirical chapter shifts the focus to policy around public funding for abortions specifically. Federal policy mandates that recipients of Medicaid be provided abortions under specific circumstances, such as threat of the woman's life or pregnancies resulting from rape. While 17 of the 50 states have opted to spend additional funds for women pursuing an abortion under other circumstances, the majority of states, 33, maintain more restrictive policies around public funding of abortions. In Chapter 4, I thus apply theories of the gendered and racialized welfare state from the previous chapters to an investigation into which states present more restrictive policies and why, using data from 2014. Results broadly mimic those from Chapters 2 and 3, with states that have higher levels of poverty and need among Black women generally failing provide more robust abortion funding. Additionally, I use this chapter to evaluate two different methodological approaches to comparative studies of the welfare state, regression and QCA. Where regression relies on linear algebra, QCA uses a Boolean approach that emphasizes the combinational and unsymmetrical nature of social phenomena. Results from the two approaches are similar to each other, yet those from QCA appear to make a stronger case for the role of Black women's needs in shaping abortion policy.

With this project I therefore contribute to the sociological literature in three ways. First, by including an empirical analysis of variation in spending for family planning and abortion services, I am applying theories put forth by welfare scholars to a less-investigated form of welfare, reproductive healthcare. In doing so, I am able to address the broader question of how states address or reproduce gender- and race-based inequalities through their policy decisions.

Second, in using both traditional regression and QCA, I am contributing to a current and ongoing methodological debate around measuring and analyzing state differences. Third, I am advocating for the importance of taking an intersectional approach to the research of welfare spending both by my methodological choices, and by my drawing from theory related to race and gender, as well as class. Gordon (1994) notes the racist and classist practices that took place in the first formalization of our definitions of welfare, and in failing to take these intersecting inequalities into account we risk oversimplifying realistically messy patterns of social injustice. In completing this project, I therefore hope to develop insights into both sociological method and theory that will contribute meaningfully to the field.

1.1 Reproductive Healthcare in the United States

Like many other social protections, support for reproductive healthcare in the United States has been in flux throughout the past century and a half and has involved a long list of stakeholders. Where medical professionals with Planned Parenthood highlight the importance of access to safe, affordable healthcare for women (Ota 2018), religious groups voice their concerns over the rights of the fetus (Greenhouse and Siegel 2012; Pew Research Center 2013; Steinberg 2003). Where global environmental scholars recognize unsustainable population growth (Sasser 2018), historians reveal the classist and racist underpinnings of population policy of the past (Borrero et al. 2014; Gurr 2011; Roberts 2014). And where politicians campaign staunchly for or against access to abortions (Carmon 2016), reproductive justice activists recognize how reproductive healthcare is tied up in a myriad of other social policies, including rights to childcare and safety (Luna and Luker 2013; Ross and Solinger 2017; SisterSong 2019). Within these debates, we come to understand the deep extent to which individual's choices around

reproduction are hardly individual matters: "the personal is political" (Hanisch 2006). In this way, we can characterize the history of reproductive healthcare policy in the U.S. as one in which motives are seldom based solely on preserving women's autonomy and social rights.

The story of American policy surrounding reproductive healthcare often begins in the late 1800s. At this time, women's and maternal healthcare primarily took place under the supervision of midwives, with limited regulation or intervention by the government. Yet throughout the latter half of the 19th century, American doctors were undergoing a process of professionalization in which decisions were made surrounding which services could fall under the jurisdiction of midwives and which could be performed solely by doctors, vastly male, certified by the American Medical Association (AMA). In an act of monopolizing healthcare choices, the AMA succeeded in illegalizing abortions except those performed under their purview. This shift is recognized as a lasting step toward removing women's bodily autonomy and placing reproductive healthcare choices in the hands of larger, male-dominated, institutions. Additionally, scholars recognize the extent to which this was a "professionalization project" (Luna and Luker 2013) meant to ensure the livelihoods of doctors, not, as many 20th century movements would argue, an issue of the "right to life."

Moving into the early 20th century, the role of the state in regulating reproductive behavior soon expanded beyond access to abortion. Racialized anxieties among White men and women grew steadily as they observed the rising birth rates of immigrant women and the decrease of births by White, middle class women of Anglo-Saxon descent. With the rise of the eugenics movement, questions as to who was morally fit to give birth and parent were intertwined with these fears, leading to policy and programs designed to curb births by women of color through contraception and sterilization, forced or otherwise. Simultaneously, abortions

among White women were discouraged by, among other things, the Comstock Act (Luna and Luker 2013). As with the AMA's regulation of abortion, these policies and protocols reveal the extent to which reproductive healthcare decisions have been maintained by these larger institutions rather than by women themselves. Furthermore, they serve to undermine the garnering of equal rights by women of color and women who could not afford the private doctors willing to bend these rules (Luna and Luker 2013).

These practices continued throughout the 20th century. Yet, the growing Civil Rights and Women's movements began to shift public and political perception on the importance of access to affordable reproductive healthcare. Nevertheless, pushback remained. While support for the Equal Rights Amendment (ERA) grew across the 1970s, its association with legalizing abortion hurt its ratification. Similarly, the decision to nationally legalize abortion with Roe v. Wade in 1973 was followed with ample opposition in the form of, for example, the Hyde Amendment, which limited how public funds could be used for said abortions. Decisions around access to reproductive healthcare remain in the spotlight today, as more states begin to pass Targeted Regulation of Abortion Provider (TRAP) laws in hopes of bringing cases up to the Supreme Court. Regardless, important to remember within these debates is that Roe was not decided on the basis of granting women access to necessary healthcare; rather it was determined that a decision to terminate a pregnancy remained under the purview of the woman and her doctor, echoing sentiments from 100 years prior. As we continue to encounter these debates surrounding equitable, non-coercive access to contraceptives, sterilizations, abortions, and sexual health education, it remains vital to consider the extent to which these policies work toward promoting or alleviating pre-existing inequalities.

In our current social-political space, we have been observing the restriction of access to reproductive healthcare services that disproportionately hurts poor women of color. This presents scholars and healthcare practitioners with a tension, in turn described as the "too much/too little dilemma" (Joffe 2018; Joffe and Reich 2014) or the "contraceptive paradox" (Mann 2018). Namely, how do we promote the equal accessibility of reproductive healthcare services without entering into coercive practices? In other words, how can reproductive healthcare policy equitably ensure women's rights to healthcare? In developing the reproductive justice approach, groups such as SisterSong recognize the importance of respecting womxn's intersecting identities and their "human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (SisterSong 2019). By applying a reproductive justice framework to current healthcare policy, perhaps some of the previous harms of policies that fail to center the experiences of marginalized women can be righted.

2 THEORY

While understudied within the welfare state literature, spending and support for reproductive healthcare is to be considered a social protection. Drawing on work by Marshall (1950) and Rawls (1971), Almgren (2017) makes a compelling argument for the consideration of healthcare as a universal right within a developed democracy. Reproductive rights carry certain social and political weight that more broad notions of healthcare may not, yet they do indeed confer the social rights, particularly to women, that assist in the actualization of political and civil rights. The argument for including spending on reproductive health in discussions of social rights is strengthened when we consider the positive impacts experienced by women, and society

8

as a whole, when these services are more readily accessible (Frost et al. 2014; Frost, Finer, and

Tapales 2008; Kavanaugh and Andersen 2016). In this section, I thus proceed first by offering

definitions of reproduction from a sociological perspective, followed by a summary of

conventional theories of welfare state development. After highlighting welfare state research on

the U.S. case, I go on to incorporate arguments on the ways in which gender and race are

intertwined with our notions of social support. A summary of the six general hypotheses

developed in this section can be seen in Table 1.1.

2.1 The Sociology of Reproduction

      The larger body of scholarship on the sociology of reproduction is a relative newcomer to

the sociological cannon. Whereas early research considered reproduction to be a biological,

linear process experienced by the individual, sociologists recognize its inherently social nature

(for a review see Almeling (2015). As such, early scholarship on the sociology of reproduction

defines reproduction as: "encompass[ing] events throughout the human and especially female

life-cycle related to ideas and practices surrounding fertility, birth, and childcare, including the

ways these figure into understandings of social and cultural renewal" (Ginsburg and Rapp

1991:311). Murphy (2012:6) expands this definition: "Reproduction was not a biological thing

with clear bounds, but a multifaceted and distributed effect in time and space, a problem both

material and political to which questions of state, race, freedom, individuality, and economic

prosperity were bound in ways that connected the micrological with the transnational via

embodiment."

      As suggested by this second definition, the four primary foci within the scholarship on

reproduction all engage with the role of the state in shaping reproductive practices. The first two,

"disciplining reproduction" (Clarke and Clarke 1998) and "reproductive governance" (Morgan and Roberts 2012) pay special attention to the role of power in reproductive politics. Together they investigate the question of "how the process of disciplining or governing reproduction varies across social realms, from medicine to the state or the family and beyond" (Almeling 2015:433). From this framework, we can understand the extent to which, for example, welfare policies that maintain family size limits serve as the state exercising coercive power onto reproductive choices. The other two perspectives, stratified reproduction (Colen 1995) and reproductive justice (Luna and Luker 2013; Ross and Solinger 2017; SisterSong 2019), emphasize how this coercive action impacts women of different identities and social positions unequally. In doing so, they advocate for reproductive policy that alleviates inequalities along multiple axes: of gender, race, class, sexuality, immigration status, and ability, among others.

Though not actively contested within this project, these theories of reproduction serve as important groundwork from which my research stems. For the rest of this project I thus rely on the notion of reproduction as a social, not merely biological or individual, phenomenon. In particular, this project speaks to the role of the state in shaping our collective understanding and experiences of reproduction, as well as how the access to wield state power is stratified by both gender and race.

2.2 Conventional Theories of Welfare State Development

Conventional theorists of the welfare state tend to distinguish between functional controls, such as state wealth and need, and the political space, as well as citizens' ability to capitalize on their political rights.[1] In particular, I draw from Huber and Stephens' (2010) notion

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[1] For reviews see: Amenta, Bonastia, and Caren (2001); Howard (1999); Myles and Quadagno (2002); Quadagno (1987); and Skocpol and Amenta (1986).

of power constellations, in which "State policy is a result of power relations in society, mediated by political institutions" (p. 13). Where Huber and Stephens (2010) incorporate gender into the conventional class-based argument, I also incorporate race, as detailed further below.

First, functionalist arguments highlight how basic need for, and ability to support, extensive social spending varies between countries. Several scholars recognize the industrial revolution as a turning point in welfare development, as the increase in state capital allows for excess funds to be reinvested in a state's citizenry (Cutright 1965; Wilensky 1975). Functionalists often operationalize this through analysis of a state's level of industrialization (Cutright 1965; Wilensky 1975) yet empirical support is lacking (Misra 2002; Skocpol and Amenta 1986). This is particularly true in the U.S. case, which some suggest is due to the development of democratic processes prior to the industrial revolution (De Swaan 1988; Quadagno 1996; Skocpol 1992). Regardless, all told, the functionalist perspective suggests that wealthier states, as well as states with higher need, will offer more generous social spending (*H1*).

While a functionalist perspective emphasizes industrialization as a catalyst for welfare state growth, others recognize industrialization as fueling a space in which workers can advocate for the social protections provided by the state. That is, with the large labor force necessary to support an industrialized state, workers gain the bargaining power needed to advocate for social (labor) protections. Thus scholars focusing on power resources suggest that the "Balance of class power determines welfare state outcomes" (Misra 2002). Furthermore, these scholars contend that the advent of social support is not in the service of the citizens, but rather the capitalists, in that supporting workers maintains their complacency within the capitalist system (Huber and Stephens 2010; Misra 2002). In this way, they highlight the tension described earlier surrounding

11

the intentions of social policy and its role in perpetuating inequality: To what extent do these social supports, in failing to address larger systems of capitalist oppression, do little to ultimately help workers? Regardless, from comparative work, we see that where there exists a strong labor party, unionization, or working class movement, there also exists a larger welfare state (Korpi 1989; Quadagno 1987; Skocpol and Amenta 1986). I thus expect that states with a more engaged populace that has broader access to participate in democratic processes will have more generous spending (*H2*).

In considering the extent to which citizens advocate for these social rights, it is equally important to understand the political context in which these actions and decisions are taking place (Barrilleaux and Berkman 2003; Cauthen and Amenta 1996; Quadagno 1987; Skocpol and Amenta 1986). When examining the role of industrialization, for example, some scholars suggest that the extent to which industrialization and democratization developed coincidentally within a state is reflected in their social spending (De Swaan 1988; Quadagno 1996; Skocpol 1992). Other factors of the political space include party identification of legislatures, with non-Southern democratic states more likely to support welfare spending,[2] as well as the role of "policy legacies" or "policy feedbacks" (Quadagno 2004; Skocpol and Amenta 1986) on later policy choices. Similarly, a more recent body of scholarship suggests that public opinion, too, falls under this approach (Brooks and Manza 2006b, 2006a; Grammich, DaVanzo, and Stewart 2004; Kail and Dixon 2011) given the close tie between public opinion and policy (Burstein 1998, 2003), particularly at the state level (Cook et al. 1992; Jelen and Wilcox 2003). Together, this

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[2] The reluctance of Southern Democrats to adopt welfare policies throughout history is well documented, and we can see the link between agendas of powerful actors and decisions by politicians especially clearly in the development of U.S. welfare policy (Gordon 1994). The relevance of the Democratic party is specific to the U.S. case, where a strong labor party is lacking (Quadagno 1987).

scholarship suggests that states with more a liberal-leaning government and populace, as well as a history of support for reproductive services, will spend more generously (*H3*).

2.2.1 U.S. Exceptionalism

This extensive literature offers evidence for the conditions associated with a developed welfare state; nonetheless, much of the original scholarship considers the U.S. as a single, national context. In reality, policy decisions around many social provisions, including healthcare, often take place at the state level, given the relative autonomy of the states inherent in U.S. social policy (Amenta and Carruthers 1988; Greentree, Lombard, and Morris 2011; Skocpol and Ikenberry 1983). As evidence of this, several studies consider the disparate health outcomes experienced by U.S. citizens based on various characteristics, including state of residence (see Wright and Perry [2010] for a review). As an implication of these discrepancies, these authors call for greater regulation of healthcare at the federal level, particularly for disadvantaged groups.

More generally, the United States is known for its two-tiered social spending system, (Goldberg 2007; Gordon 1994; Hacker 2002; Lewis 1992; Sainsbury 1996). Here, top-tier programs, such as unemployment and social security, have relatively generous funding and public support, while second-tier programs, colloquially referred to as "welfare" in the U.S., remain means-tested and meager, with recipients often being portrayed as "undeserving." In this way, the U.S. serves as a particularly unique location for studying how cultural and political forces influence spending for social welfare, particularly for programs that are relegated to this "second tier" such as spending for reproductive healthcare.

2.3 Racialized and Gendered Welfare State

In their gender-based criticisms of both Esping-Andersen (1990) and Marshall (1950), many feminist scholars point to the male-centered definitions and measures of welfare employed by these authors (Bacchi 1999; Lewis 1992; O'Connor, Orloff, and Shaver 1999; Orloff 1996; Sainsbury 1996). Other scholars equally recognize the role of racialized institutions in shaping policy decisions, particularly within the U.S. case (Brown 2013; Misra 2002; Reese, Ramirez, and Estrada-Correa 2013). Given Almeling's (2015) call for reproductive research to more deeply incorporate racialized and gendered social processes, for this project I draw from research by welfare state scholars who recognize the role of race and gender in policy decision-making, as summarized below.

2.3.1 Intersectionality

In order to speak to the role of race and gender in shaping social and political processes, I first describe the framework of intersectionality and its application to the welfare state literature. Intersectionality as a formal field of research comes from work by Collins (2000), Crenshaw (1991), and Hooks (2000). These scholars, among others, recognized that one's lived experience is not a strict summation of each of their various social identities. Rather, a combination of a myriad of social factors may result in differential identity development and treatment by both individuals and institutions. In their advocating for the use of a reproductive justice framework in research, policy, and practice, groups such as SisterSong (2019) directly apply such intersectional perspectives.

More recently, scholars have questioned what it means to pursue truly intersectional research. These discussions have taken the form of both definitional and methodological debates.

14

In considering the perspective of socialist feminists, for example, Zinn and Dill (1996) note that the evaluation of gender and class inequalities notably excludes race, and question the extent to which this represents intersectionality. Choo and Ferree (2010) provide a summary of the various descriptors scholars have used in their discussion of these experiences, such as "complex inequality" (McCall 2001), "matrix of domination" (Collins 2000), or "intersectional" (Crenshaw 1991). Similar definitional questions are posed by Collins (2015) and Davis (2008). Collins (2015) and others also comment on how intersectionality gets operationalized from an analytic perspective. These authors indicate how intersectionality expands beyond race-class-gender to include identities related to sexuality, age, and ability.[3]

Together, this literature suggests that the identities of race and gender play a role in the functional-, power-, and political-based processes associated with welfare state development. That is, while social spending support is clearly a class issue, it is just as equally a race and gender issue as well.

2.3.2 Gender and the Welfare State

In response to these seemingly gender-neutral economic- and politics-based explanations, several feminist scholars criticize this lack of reference to gender and its operation through the state. From Acker (1990, 2006) and Walby (1994), we understand how policy that may be intended to be gender-neutral is more realistically gender-blind in its assumption of a man as the default citizen. First, these authors note how programs defined broadly as welfare do not necessarily equally serve men and women (Bacchi 1999; Lewis 1992; O'Connor et al. 1999; Orloff 1996; Sainsbury 1996). This is especially evident in the US case; whereas we see praise

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[3] More on the methodology on intersectional research can be seen in the "Methodology" section below.

for Social Security and unemployment insurance, both of which are targeted at (predominantly male) workers, we see stigmatization of programs such as Aid to Families with Dependent Children (AFDC), and Temporary Aid for Needy Families (TANF), which are directed primarily at mothers and children (Goldberg 2007; Gordon 1994; Lewis 1992; Sainsbury 1996). This imbalance can further be seen in the fact that family assistance is means-tested, and very limited in scope[4]. Additionally, given the "feminization of poverty" described by Pearce (1978), and the traditional gender roles dictated to women, their need for state-sponsored programs is unique. In this way, we are concerned with not just the extent of poverty within a state, but specifically the proportion of women that are experiencing poverty. This leads to the hypothesis that higher levels of women in need of publicly funded healthcare will reflect more generous spending on the part of the state (*H4*).

Many feminist scholars criticize the male-centered definitions and measures of welfare employed by conventional welfare state scholars, yet few push definitions of welfare spending past those of monetary assistance for individuals or families. O'Connor et al. (1999) notably devote space in their book to discuss the gender implications of patriarchal states, including those related to family planning, abortion, and eugenics. In particular their discussion of reproductive rights as medical versus body rights helps to situate these policies within frameworks developed by previous scholars. Nevertheless, the extent to which scholars have empirically tested how different factors are related to spending for reproductive care, as they have for other types of welfare spending, remains limited. Therefore a more gender-sensitive approach to the study of welfare state development does well to consider outcomes either

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[4] With the 1996 welfare reform, for example, a mother can only be on TANF for a maximum of two years of her life (Hahn et al. 2017).

directly targeted at women (i.e. reproductive healthcare) or else stereotypically associated with women's heteronormative roles (e.g. healthcare).

When considering the unique position of reproductive healthcare within the social spending hierarchy, it is worthwhile to note the fundamentally gendered nature of reproductive spending. A woman's traditional familial role associates her with care-taking at large (Knijn and Kremer 1997; Ray, Gornick, and Schmitt 2010; Shelton and John 1996), and needs for reproductive healthcare remain that much more gender-specific. Of studies that explore the gendered nature of welfare spending within the U.S., most have focused on those programs geared toward female heads-of household (Bentele and Nicoli 2012; Kail and Dixon 2011; Misra and Moller 1998; Moller 2002; Pearson 2007). Programs such as Aid to Dependent Children (ADC), AFDC, and TANF all provide assistance to women, but it is via their role in caring for children. It is uniquely with reproductive healthcare that we see spending targeted at women themselves, regardless of their parental status. Juxtaposing correlates for spending for reproductive care against those previously studied, like AFDC, allows comparison of two contrasting images of women in society: woman-as-mother and woman-as-potential mother. Thus in exploring variation in spending for reproductive healthcare, this project expands our definition of social spending and social rights.

In addition to the gendered nature of welfare's operationalization, a question remains as to what sorts of environments lead to more or less welfare generosity under a feminist lens. This has also been addressed by feminist scholars, who note, for example, that not only do the political views of those who have power matter, but also the gender of those with political power (Bolzendahl and Brooks 2007; Paxton, Green, and Hughes 2008; Poggione 2004). Whether this be operationalized as the proportion of female legislatures (Bolzendahl and Brooks 2007;

17

Caiazza 2004; Cowell-Meyers and Langbein 2009), or the proportion of women voters, women's representation matters. Similarly, as increased unionization is associated with more generosity, so too is women's participation in the labor force, and the representational power that it brings (Volgy, Schwarz, and Gottlieb 1986). From this work, I predict that states with more women in legislation and proportionally more women actively voting will result in increased generosity of spending for welfare services (*H5*).

2.3.4 Race and the Welfare State

Similarly, other scholars indicate the role that race and racism play in shaping welfare policy. Many of these studies are historical in nature, pointing to specific points in America's history when policies failed to help, or explicitly disenfranchised, people of color, and women of color in particular (Gordon 1994; Quadagno 1996; Schram, Soss, and Fording 2003). In considering family assistance spending, for example, we see how Black women were excluded from the formal decision-making processes surrounding the 1935 Social Security Act (Gordon 1994). Furthermore, many of these policies were written with the purposeful exclusion of Black laborers, as evidenced by the lack of economic protection granted to agricultural and domestic workers (Gordon 1994; Misra and Moller 1998). We see this further playing out in the assumption of White, upper-middle class, Protestant parenting norms as the measure for proper parenting techniques (Gordon 1994).

In describing the literature on the racialized welfare state, Reese et al. (2013) highlight two conflicting theories. First, the "power in numbers" or critical "mass" hypothesis (Blalock 1967; Glenn 2004; Kanter 2008; McAdam 2010) suggests that the larger the presence of a minoritized group, the more power they will have in shaping a legislative agenda. At odds with

this is the "threat" (Key 1949) or "power threat" (Blalock 1967) hypothesis, which suggests that as a minoritized group grows, the group in power (e.g. upper-middle class White Americans) begins to feel threatened, and thus pushes back against these groups through legislation. Work by Brown (2013) similarly suggests that racialized conflict leads to more restrictive welfare policies.

To better understand these phenomena, I draw on the work by Omi and Winant (1986) as well as the follow-up volume HoSang, LaBennett, and Pulido (2012). In their foundational work, Omi and Winant (1986) describe the ways in which our perceptions of race are constantly formed and reformed through social interactions and institutions. Similarly, critical race theory emphasizes the role of a White supremacist state in perpetuating injustices against people of color (Delgado and Stefancic 2012; Feagin 2013). In this way, we can recognize how policy intending to protect citizens may indeed fail to account for the experiences of people of color, or purposely apply additional injustices. More empirically, research by scholars such as Dawson (2003), Hutchings and Valentino (2004), and Whitby (1987) describes how power dynamics and political institutions are shaped by the needs of African-American voters. Importantly, scholars also highlight how these racial processes intertwine with some of the gendered processes described above (Kandaswamy 2012).

Additional empirical evidence reinforces the association between racial politics and social spending generosity. Kail and Dixon (2011), Misra and Moller (1998), Moller (2002), Reese (2001), and Sander and Giertz (1986), among others, find that the racial makeup of a state impacts welfare generosity such that African-Americans' needs remain under-supported. On the other hand, the racialized history of family planning and related services in the U.S. (Correa and Reichmann 1994; Farrell, Dawkins, and Oliver 1983; Greil et al. 2011; Gurr 2011; Joffe and

Parker 2012; King and Meyer 1997; Roberts 2014; Volscho 2010) might suggest that a state having higher proportions of women of color would be associated with increased funding for these services. Nevertheless, recent reports indicate the lack of availability of these services, particularly for women of color (Howell and Starrs 2017). Here I thus hypothesize that spending generosity will be more reflective of the needs of White women than of Black women (*H6*).

3 METHODOLOGY

Research on the welfare state has long served as a platform for the debate on quantitative methodological choices and preferences. As evidenced by empirical tests mentioned above, many welfare scholars opt for traditional regression techniques when examining variations in spending between states or over time. Regression is often favored by the comparative sociological community, given its popularity in the social sciences more broadly (Goertz and Mahoney 2012). Yet correlation-based techniques have their limitations (Ragin 2008, 2014).[5] Similarly, scholars applying an intersectional framework question the extent to which these more conventional methods are able to capture the multi-faceted nature of identity-based inequities that underpin this perspective (McCall 2005; Prins 2006). Often a preference for qualitative over quantitative methods is found within this literature, putting it somewhat at odds to traditional approaches to studying comparative welfare states.

One method that has been developed to somewhat bridge the gap between quantitative and qualitative paradigms is qualitative comparative analysis, or QCA (Ragin 2008; Rubinson and Ragin 2007). First, where regression requires many cases over many years in order to achieve statistical significance, QCA is suited for the "small N" analysis. Second, where

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[5] For an in-depth comparison of these approaches, see the Symposium on Methodology in Comparative Research in Mjöset and Clausen (2007).

regression results are based on correlations between variables, those from QCA reflect membership of cases into either fuzzy (scaled) or crisp (nominal) sets. In applying set theory, connections in QCA are allowed to be asymmetrical (for example, all states with higher spending may have democratic governors, but not all democratic governors necessarily hold office in states with high spending). The same is not true for correlational relationships, and in this way, we can consider a more nuanced form of what it means for two conditions (or variables) to be related to each other. Finally, QCA's use of combinations of conditions rather than a single correlational relationship suits research that takes an intersectional framework.[6]

Thus, within this project, two different methodological techniques are pursued: regression (including ordinary least squares, panel models, and logistic) and QCA. Specifically, Chapter 2 makes use of the longitudinal data on Medicaid spending by conducting panel regressions, as well as OLS regressions on averaged data and one-year lagged regressions on the most recent annual data. In Chapter 3, I again employ OLS regression on averaged and annual data on spending for family planning at three specific time points. Finally, Chapter 4 offers a side-by-side comparison of fuzzy-set QCA and binary logistic regression, given my dichotomous outcome (whether or not a state has restrictive public funding for abortion). Here, in addition to providing robustness checks with the use of both methods, I am also able to compare the extent to which each is suited for evaluating questions of social spending variation.

4 DATA

Data for this dissertation come from a long list of publicly available sources. Here I offer a description of the data collection process, as well as suggestions on the limitations of the

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[6] The exception to this is in the inclusion of an interaction term, but a single interaction term still remains a poor proxy for the complicated ways in which multiple social factors overlap with each other to produce an outcome.

specific explanatory factors I have chosen. More detail on the specific variables/conditions can be seen in each empirical chapter.

A full list of variables and their sources can be seen in Table 1.2. The selection of these specific sources was made based on availability and reliability of each dataset. These include governmental publications from, for example, the Census Bureau, the Bureau of Economic analysis, and the Bureau of Labor Statistics. Additional data was culled from sources more narrowly focused on specific topics, such as state spending data from the National Association of State Budget Officers, party affiliation data from the National Council of State legislatures, and female political representation statistics from the Center for American Women and Politics. Data related to reproductive healthcare comes predominantly from reports by the Guttmacher Institute. This Institute is a non-profit organization that conducts scholarly research on and advocates for reproductive and sexual health, both in the U.S. and globally. While their role as advocates may suggest bias in these reports, the methodological rigor described as well as the credentials of the authors offer validity to their findings.

In collecting this data, I endeavored to select sources that were consistent across time points and had been previously used by scholars of the U.S. welfare state. Thus, even though the time span that I could study for this project, 2006-2016, remains somewhat limited, I am able to aggregate the most currently relevant data. Future research would benefit from an even more longitudinal approach to spending on healthcare at large, and reproductive healthcare specifically.

Another major limitation to using some of these aggregate sources of data is the extent to which they allow me to target the sometimes more subtle role of race and gender in shaping policy decisions. For example, while this data offers a comprehensive view of state population

and voting counts, data on Black population and voting rates in which these numbers are particularly small become unreliable.[7] Similarly, I was able gather information on female political representation, but I was not able to find data on Black, and particularly Black female, representation as readily. Going forward, I would hope to be able to incorporate more nuanced measures of Black political and class power.

Similarly, even with the long list of factors I have incorporated in this project, there are several other factors I could not include given the scope of the project. For example, just as I disaggregate measures such as poverty and voting participation by race, so too would I like to disaggregate unemployment. Additionally, other measures related to both functional and power/political perspectives could easily be included, such as labor force participation, judicial conservatism, and the presence of social movement organizations. Perhaps a gradient scale for the severity of Jim Crow laws would prove particularly illuminating. Nevertheless, with this wide variety of data I am able to represent the range of welfare state factors, and in particular highlight how these are shaped by race and gender processes within the state.

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[7] Indeed, for certain state-year combinations, Black voting data is unavailable (see chapters for detail). In other cases, the denominator was particularly small such that percentage calculations remain biased upward for these measures.

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Table 1.1 Summary of hypotheses

Theory		Hypothesis
Functional	1	States with greater wealth as well as greater levels of poverty will spend more generously.
Power/Political	2	States with greater access to and engagement with the political process will spend more generously.
	3	States with a more liberal populace, government, and policy history will spend more generously.
Gender	4	Spending generosity will reflect the needs and representation of women in the population.
	5	States with higher female representation in the legislature will spend more generously.
Race	6	Spending generosity will reflect the needs and representation of White people over Black people.

Table 1.2 Variables and sources

Key:

ACS = American Community Survey	CPS = Current Population Survey
B = Berry et al. 2010	NASBO = National Association of State Budget Officers
BEA = Bureau of Economic Analysis	NCSL = National Conference of State Legislatures
BLS = Bureau of Labor Statistics	P = Pew Religious Landscape Study
BOS = Book of the States	SL = Stateline (Pew)
CAWP = Center for American Women and Politics	✝ = Missing data for some state-year combinations. See text for details.

Type	Variable	Chapter	Description	Source
Outcome	Medicaid spending per GDP	2	Percentage	NASBO, BEA
	Medicaid spending per total social spending	2	Percentage	NASBO
	Family planning spending per GDP	3	Percentage	GI, BEA
	Family planning spending per total social spending	3	Percentage	GI, NASBO
	Restrictive abortion policy	4	0 = state spends additional funds outside of federally-mandated circumstances; 1 = state spends public funds only in federally-mandated circumstances	GI, NWLC
Functional	GDP per capita	2, 3, 4	In millions of dollars (2016 dollars when adjusted for inflation)	BEA
	Gini coefficient	2, 3, 4	Income inequality scale: 0 = total equality; 1 = total inequality	ACS
	Unemployment rate	2, 3, 4	Percent unemployed in population 16 years and older	BLS
	% under 18	2, 3, 4		ACS
	% 65 and older	2, 3, 4		ACS
	Poverty status	2, 3, 4	Percent living below poverty level, for whom poverty status is determined	ACS

Table 1.2 *Continued*

Type	Variable	Chapter	Description	Source
Power/Political	Unionization	2, 3, 4	Percent of employed, members of unions	BLS
	Voter turnout	2, 3, 4	Percent of 18+ citizens who voted in previous presidential election	CPS
	Democratic gov't	2, 3, 4	0 = R gov/R leg; 1 = I gov/R leg or R gov/S leg; 2 = D gov/R leg or I gov/S leg or R gov/D leg; 3 = D gov/S leg or I gov/D leg; 4 = D gov/D leg	BOS
	Voter ID laws	2, 3, 4	0 = none; 1 = non-strict non-photo; 2 = non-strict photo; 3 = strict non-photo; 4 = strict photo	NCSL
	South	2, 3, 4		Census
	Pre-Roe abortion law	3, 4	0 = illegal; 1 = legal in some or all circumstances	SL
	% Evangelical	4		P
	% Mainline Protestant	4		P
	% Catholic	4		P
	Religiosity	4	Avg. importance of religion on 4-pt. scale: 0 = not at all important; 1 = not too important; 2 = somewhat important; 3 = very important	P
	Liberal political ideology	4	Political ideology scale: 0 = conservative; 1 = liberal	B
	% Support legal abortion	4	Percent support legal abortion in some/all cases	P

Table 1.2 *Continued*

Type	Variable	Chapter	Description	Source
Gender	Poverty by gender			
	Male	2, 3, 4	Number of men living below poverty level, per men for whom poverty status is determined	ACS
	Female		Number of women living below poverty level, per women for whom poverty status is determined	
	Need	3, 4	Number of women in need of publicly funded contraceptive services per total number of women in need of contraceptive services	GI
	% Female	2, 3, 4		ACS
	Voter turnout by gender	2, 3, 4		CPS
	Male		Number of male citizens who voted in previous presidential election per 18+ male citizens	
	Female		Number of female citizens who voted in previous presidential election per 18+ female citizens	
	% Female legislature	2, 3, 4		CAWP

Table 1.2 *Continued*

Type	Variable	Chapter	Description	Source
Race	Poverty by race	2		
	White		Number of White people living below poverty level, per White people for whom poverty status is determined	ACS
	Black		Number of Black people living below poverty level, per Black people for whom poverty status is determined	
	Female poverty by race	3, 4		ACS
	White female		Number of White women living below poverty level, per White women for whom poverty status is determined	
	Black female		Number of Black women living below poverty level, per Black women for whom poverty status is determined	
	Need by race	3, 4		GI
	White female		Number of White women in need of publicly funded contraceptive services per total number of White women in need of contraceptive services	
	Black female		Number of Black women in need of publicly funded contraceptive services per total number of Black women in need of contraceptive services	
	% White	2, 3, 4		ACS
	% Black	2, 3, 4		ACS
	Voter turnout by race	2, 3, 4		CPS
	White		Number of White citizens who voted in previous presidential election per 18+ White citizens	
	Black[+]		Number of Black citizens who voted in previous presidential election per 18+ Black citizens	

CHAPTER 2

TEMPORAL AND GEOGRAPHIC VARIATION IN MEDICAID INVESTMENTS

1 INTRODUCTION

The United States serves as a unique case for understanding changes in healthcare policy. Unlike many of its wealthy, democratic counterparts, the U.S. fails to provide universal public healthcare to its citizens. Access to quality healthcare has recently been brought to the political forefront, thanks to the passage of the Affordable Care Act in 2010, followed by a promise for its repeal from the current administration. Not surprisingly, it remains starkly on the public's mind as well (Grogan and Park 2017). In order to better understand the advent of recent changes, as well as how they are manifested differently in different parts of the country, I look to the literature on welfare state development at large.

Historically, much of the literature devoted to welfare state development in the U.S. has been concerned with spending for social security and unemployment. More recently, scholars have indicated the importance of expanding our notion of welfare spending to include other forms of support (Bentele and Nicoli 2012; Kail and Dixon 2011; Moller 2002), such as Aid to Families with Dependent Children (AFDC) or Temporary Assistance to Needy Families (TANF). Citing both their historical development and current manifestation, these authors indicate the utility of researching the funding of these services separately from the more robust unemployment or social security funding.

From this understanding of the roots of welfare state development, many scholars have further pursued the question of how welfare states differ in terms of their healthcare services. In particular, Almgren's (2017) recent work combines Marshall's (1950) and Rawls' (1971)

theoretical frameworks to highlight the importance of considering healthcare among those rights inherent to citizenship. I thus use this chapter to apply these conventional theories of welfare state spending to an under-studied topic in the welfare state literature, publicly funded healthcare in the United States.

Several scholars have critically examined the differential health outcomes of citizens living in various welfare state regimes. Overall, studies highlight the positive impact a protective welfare state regime has on its citizens' health (Muntaner et al. 2011). For example, In Olafsdottir's (2007) comparison of the U.S. and Iceland, the author finds that in Iceland, wealth is less associated with positive health outcomes than in the U.S., citing its protective social net. Similarly, Beckfield and Bambra (2016), claim that "the U.S. mortality disadvantage is, in part, a welfare state disadvantage" in their study of the relatively high mortality rates of the U.S. population. The impact of disparate health outcomes on public opinion of healthcare spending is also, importantly, tempered by the model that each country uses (Kikuzawa, Olafsdottir, and Pescosolido 2008).

While this extensive literature offers evidence for the connection between welfare state regime and health outcomes, most of these studies consider the U.S. as a single, national context. In reality, policy decisions around many social provisions, including healthcare, often take place at the state level, given the relative autonomy of the states inherent to U.S. democracy. As such, several studies consider the disparate health outcomes experienced by U.S. citizens based on various characteristics, including state of residence (see Wright and Perry [2010] for a review).

Part of the difficulty of studying healthcare in the U.S. context is the patchwork nature of the U.S. health insurance process. This comes in part from the fact that even within a national policy context, many healthcare-related decisions are relegated to the states. This also arises due

to the availability of private insurance to cover Americans' healthcare costs. Importantly, when measuring the availability and presence of public health insurance in the U.S. context, I am not necessarily measuring the extent to which Americans as a whole are protected from healthcare costs. Rather, I am taking the standpoint offered by the welfare state literature that indicates the importance/necessity of a state providing support for basic needs to its citizens, regardless of their status (Almgren 2017). In the U.S. case, most often, private insurance is tied to employment or familial relations, thus resulting in its failure to serve as a universal good. Therefore, conclusions that I draw here, based on access to public insurance, though not speaking to the *use* of health insurance in the U.S. at large, are still meaningful in their implications for better understanding support for universal basic rights.

In this chapter, I explore the extent to which support for Medicaid varies both over time and between states. I perform a series of regressions on two outcomes: Medicaid spending per state GDP and per total social spending. My primary analytic technique is panel-corrected standard error regression, as data represents spending both over time and between states. The outcome itself comes from the National Association of State Budget Officers' reports from the years 2006-2016. In doing so, I am able to capture the wide differences in political contexts between states, as well as changes in funding for Medicaid over time, including before and after the passage of the Affordable Care Act. Thus, this chapter offers an extension of the welfare state literature to a particularly timely topic, as well as suggests that state choice to invest more or less in their Medicaid program is predominantly driven by state wealth and need (though mediated by race), and to a lesser extent, political factors. In doing so, it sets the stage for the following two empirical chapters.

1.1 Public Healthcare in the United States: Medicaid

The United States is often typified in the comparative literature as an "exceptional" case when it comes to its perspective on social politics. This categorization is based on, among other things, America's emphasis on equality over equity, its delegation of responsibilities to state and local levels (Almgren 2017), and its rhetoric of "rugged individualism" as being vital to American economy and democratic spirit. Healthcare is no exception to this exceptionalism. Rather than being included in a package of guaranteed rights from the state, like all other industrialized democracies (Quadagno 2006), U.S. health insurance is tied to employment. This has historically left large swaths of the American public without affordable healthcare (Brown 1983). Thus, in order to address the needs of uninsured Americans, the federal government has, on-and-off, implemented joint federal-state grant programs directed toward healthcare since the early 1900s (see Brown [1983], Haeder and Weimer [2015], and Moore and Smith [2005] for summaries). In particular, the Social Security Act of 1935 provided funding for healthcare services directed at specific groups: mothers, children, the elderly, and the blind. Importantly, however, efforts to consider national health insurance programs within the Act were quashed, in part due to lobbying by the medical industry (Brown 1983).

It was with the 1965 Social Security Act amendments that Medicaid itself took shape. In its current form, Medicaid serves approximately 20% of the American public (Garfield, Rudowitz, and Damico 2018). Yet the development of the program has been closely tied with welfare at large. Indeed, eligibility was originally based on participation in welfare programs such as Aid to the Blind, AFDC, and Aid to the Permanently and Totally Disabled (Moore and Smith 2005). This importantly excluded certain individuals who were in need of access to reduced healthcare costs but were not eligible for welfare funds. Additionally, implementation

across the states was far from consistent. It took 16 years before all fifty states offered Medicaid programs (Haeder and Weimer 2015), and those states with the poorest populations often offered the most limited services (Moore and Smith 2005). Overall, this resulted in a program that "even the authors saw…as an important, but limited step which left large gaps in coverage" (Moore and Smith 2005:51).

In this way, we can recognize certain parallels between the development of Medicaid and the development and implementation of welfare at large. First, when the Social Security Act passed, it contained a limited version of those services advocated for by women's groups, and in particular, by Black women (Gordon 1994). These activists recognized the importance of robust healthcare coverage in working toward establishing a more equitable society, yet their cause was overruled by the time the Act landed on Roosevelt's desk. Second, it is worth noting the extent to which Medicaid may be considered on the "lower tier" of social services (Brown 1983; Hacker 2002; Meyer 1994).[1] Where Medicare, a social insurance program, is seen as a service earned by the deserving, the eligibility requirements of Medicaid, a public assistance program, remain highly contested (Garfield et al. 2018). While the Affordable Care Act allowed for Medicaid expansion, states were still given the right not to opt-in to this expansion, with results echoing those from its initial implementation in terms of the poor being disproportionately affected (Pear 2013). Third, scholarship recognizes both the extent to which people of color, and women of color in particular have persistently worse access to quality healthcare (Greene, Blustein, and Weitzman 2006; Sommers et al. 2017). From Meyer (1994: 12), "the U.S. long-term care system stratifies by default; to the extent that U.S. social policy fails to take steps to alleviate gender and race inequality generated by social and market forces, the welfare state stratifies by gender and

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[1] This division is questioned by Howard (1999).

race." Thus, the precarious nature of public assistance-based aid in part perpetuates the discrimination experienced by individuals in these groups. All told, this results in a program that almost belongs in a category of its own when being compared to the healthcare programs in other countries.

2 THEORY

I employ racialized and gendered theories of welfare state development in exploring variation in Medicaid spending by state and over time. The literature on the welfare state is well-developed, though tests are more often conducted on cross-national datasets and to spending outcomes other than healthcare. Nevertheless, it serves as a good foundation for establishing the extent to which healthcare spending follows conventional theories of welfare state development. Hypotheses here reflect those from the introductory chapter and are summarized in Table 1.1.

2.1 Conventional Theories of Welfare State Development

As offered in more detail in Chapter 1, this literature is often divided into two groups: functional arguments of wealth and need, and power/political arguments of citizen engagement and political context. First, functionalists argue that state wealth and need drive spending (Cutright 1965; Wilensky 1975), so that we would expect that states with higher GDP per capita would spend more generously, as would states with higher levels of poverty (*H1*). Second, other scholars emphasize the role that collective tools of the citizen play (Korpi 1989; Misra 2002; Quadagno 1987; Skocpol and Amenta 1986), such that with higher engagement in the form of unionization and higher voter turnout we would expect to see more generous Medicaid spending (*H2*). Third still others contend that political makeup of the state legislature, alongside access to

a legacy of support for social spending, engenders more robust welfare state support (Barrilleaux and Berkman 2003; Cauthen and Amenta 1996; Quadagno 1987; Skocpol and Amenta 1986). Here, thus, we would expect that more democratic-leaning states have more generous spending, as would states without strict voter ID laws (*H3*). In addition, political institutionalists acknowledge the role of the political legacy of the South as an exception in both the historical agenda of the Democratic party as well as its agricultural legacy (Gordon 1994). Research suggests that Southern states will tend to have less support for social services than their non-Southern counterparts (*H3*).

2.1.1 The U.S. Case

More specific to the United States, one set of studies considers why states exhibit greater or lesser support for healthcare spending. Miller (2005) offers an in-depth summary of studies dedicated to explaining variation in healthcare policy and spending in the U.S. In doing so, he provides a useful model for understanding the combination of factors both internal and external to a state that impact healthcare policy decisions, while highlighting a lack of attention to the impact of political factors. Some research indicates political predictors have a limited association with Medicaid spending (Buchanan, Cappelleri, and Ohsfeldt 1991), though most suggest it confers some impact.

Grogan (1994), for example, develops a political-economic theory to explain variation in Medicaid policy, highlighting that different indicators related to Medicaid policy are reflective of different political processes. Similarly, Jacobs and Callaghan (2013) point to the importance of politics, but emphasize that we must look beyond party preference to understand deeper causes of variation in Medicaid policy, particularly for recent expansions. Where Grogan and Patashnik

(2003) highlight the lasting impact of how Medicaid policy unfolded in 1965, Quadagno (2010) points to the healthcare reform bills in 2010 as an example of how policy is not solely reflective of its roots. Finally, in an attempt to uncover why the U.S. remains a public healthcare laggard, Quadagno (2004) points to the roles of medical professionals acting in the political sphere as stakeholder mobilizers.

2.2 Race, Gender, and the Welfare state

With an acknowledgement of the roles that race and gender play in shaping policy in general, and healthcare policy in particular (Gordon 1994; Luna and Luker 2013), I also draw from the literature on the racialized and gendered U.S. welfare state. Within the literature on race and the state, scholars recognize that the presence of a minoritized group in a state can shape spending outcomes (Reese, Ramirez, and Estrada-Correa 2013). The threat hypothesis (Key 1949), for example, suggests that as the presence of a minoritized group rises, policy is developed in opposition to their collective needs and desires. Simultaneously, the power in numbers hypothesis (Blalock 1967) would suggest otherwise: that with larger proportions of minoritized citizens in a state, the more generous spending is. The opposing and often non-linear relationships described by these theories make interpretation for this project difficult, particularly given the macroscopic scale of the data. Where these debates emphasize the role of representation within the population in shaping policy, another set of scholars describe the extent to which policy itself alleviates or aggravates preexisting instances of inequality (Delgado and Stefancic 2012; Meyer 1994). From this literature, we would expect that regardless of population representation, Medicaid spending generosity would be more representative of the needs of

White than Black citizens. In other words, I expect high White representation and poverty levels to be more tightly associated with spending generosity than those for Black Americans (*H6*).

In the gendered welfare state literature, scholars point to the role that female makeup of the legislation plays in shaping spending outcomes (Bolzendahl and Brooks 2007; Paxton, Green, and Hughes 2008; Poggione 2004). The United States is known for its two-tiered social spending system, in which top-tier programs, such as unemployment and social security, have relatively generous funding and public support. Meanwhile second-tier programs, such as AFDC and TANF, remain means-tested and meager, with recipients often being portrayed as "undeserving" (Goldberg 2007; Gordon 1994; Lewis 1992; Sainsbury 1996). As these scholars and others (O'Connor et al. 1999; Orloff 1996; Sainsbury 1996) suggest, social spending decisions do not take place in a gender-neutral vacuum. Rather, policy decisions based on "women's issues," including healthcare, can be reflective of gendered processes within the state. Specifically, research (Bolzendahl and Brooks 2007; Caiazza 2004; Cowell-Meyers and Langbein 2009) suggests that female representation is often positively associated with more generous social spending. Thus I expect that states in which a higher proportion of their legislature is female will tend to offer more generous Medicaid spending (*H5*). Additionally, this literature highlights the importance of examining consequences of female poverty, not just overall poverty on spending generosity. In consideration of the "feminization of poverty" (Pearce 1978), alongside the understanding of healthcare often falling under the "women's domain" (Knijn and Kremer 1997; Ray, Gornick, and Schmitt 2010; Shelton and John 1996) I would expect that state spending will be more reflective of women's representation and poverty levels than men's (*H4*).

3 DATA AND METHODS

3.1 Data

The variables described below are selected based on the theoretical framework offered above. Measures themselves come from a wide range of publicly available datasets. Examples include the U.S. Census, the Bureau of Economic Analysis, and the U.S. Department of Labor. Data represents information from 2006-2016. This time period is chosen for a few reasons. First, collecting data across a range of years allows me to investigate the extent to which variation exists both between states and over time, and allows for the application of more sophisticated regression techniques. Second, I want a relatively recent set of data so that I can investigate variations within the context of recent healthcare policy changes (e.g. the Affordable Care Act). Third, data availability to a certain extent limits the years for which the wide variety of data used in this chapter, and larger dissertation, can be found. Regardless, the public availability of these datasets, consistency in data collection processes, and reliability of their sources offers confidence in the findings described below.

Descriptive statistics for all variables can be found in Table 2.1.

3.1.1 Dependent Variable

My dependent variable is developed using data from the National Association of State Budget Officers (NASBO). Annual state budgets, available on their website, detail the total amount of state spending, broken down by category (healthcare, education, transportation, etc.). This measure of spending for Medicaid allows us to compare levels of spending within the context of overall social spending. Though Medicaid is a joint state-federal program, this measure includes only that amount allocated by the state, ensuring validity in observed variation.

To create my primary dependent variable, I divide this measure by *state GDP*, as given in the Bureau of Economic Analysis (BEA). This allows us to consider Medicaid spending normalized to overall state wealth, answering the question: If a state has sufficient wealth, are they dedicating these funds to Medicaid? [2] My secondary dependent variable takes *total social spending*, as derived from NASBO's tabulations, as the denominator. Analysis of this variable points to a similar, but slightly different, question: If a state invests in social spending more broadly, what proportion of that is being dedicated to public healthcare in the form of Medicaid spending?

3.1.2 Independent variables

Independent variables, based on those used in previous literature, come from a variety of publicly available sources and represent the theories of welfare state development described above. To capture conventional functionalist controls, I include six main predictors. First, representing the state's overall capacity to spend on Medicaid, are state *GDP per capita* (in millions of 2016 dollars), and *Gini coefficient*, which measures the level of inequality within a state (higher Gini coefficient indicates higher levels of inequality). In consideration of a state's need for social support, I add the *unemployment rate* and *poverty rate* (the number of citizens living below the poverty level as a percent of total for whom poverty status is determined). As population controls I include percent under 18 and percent 65 and older.

To capture conventional measures related to theories of power and politics within the state, I evaluate five additional variables. *Voting rate* reflects the percent of citizens 18 and older

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[2] Scholarship indicates the various ways in which welfare state generosity can be measured (Tropman and Gordon 1978). While other specifications are worth exploring, in this paper I investigate only the two iterations described below. Future research should further consider the implications of various iterations of this outcome.

who voted in previous presidential election, and *unionization* gives the number of employed who are members of unions out of the total number of employed. I also include a measure of the extent to which state government leans toward the *Democratic party*. This measure is constructed as a five-point scale based on governor party and legislative majority for each state-year combination.[3] To capture the political and economic history of Southern exceptionalism in the Democratic party, I include a dummy variable of whether or not the state is in the *South*. In addition, given the importance of ability to access voting rights, I include a measure of state *voter ID laws* (higher values indicating stricter laws).

In wanting to investigate the extent to which gendered and racialized processes shape the influence of these power and political variables on my outcome, I disaggregate several by both *gender* and *race*. This includes *poverty rate*[4] and *voter engagement*.[5] In order to probe the extent to which overall gender and race makeup of the state influence spending, I also include *proportions of men, women, Black, and White* respondents in subsequent models. Finally, I consider the role the gender plays through political institutions by adding a measure of the *percent of females within the state legislature*.

3.2 Methods

In this chapter I use Stata 13 (StataCorp 2013) to run a series of models on two dependent variables: Medicaid spending per GDP and Medicaid spending per total social spending. My

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[3] Specifically: 0 = Republican governor and legislature; 1 = independent Governor and Republican legislature or Republican governor and split legislature; 2 = Democratic governor and Republican legislature or independent governor and split legislature or Republican governor and Democratic legislature; 3 = Democratic governor and split legislature or independent governor and Democratic legislature; and 4 = Democratic governor and Democratic legislature.

[4] Normalized to the size of the subset population so that I calculate, for example, the number of White people living below the poverty line as a percent of the total number of White people.

[5] Due to availability of voting data, Black voter participation is unavailable for: ID, MT, SD, VT (2004); and ID, MT, SD (2012). These cases are excluded from the model in which this variable is tested.

primary tool is panel-corrected standard error regressions correcting for AR-1 correlations. This method is ideal for this type of data since I have outcomes that vary both over time and between cases (Beck and Katz 1995). In this way, this method[6] corrects standard errors of coefficients for the lack of independence of observations within a specific state over time, which would otherwise violate OLS assumptions. Acknowledgement of the AR-1 correlations specifically highlights the tight correlation between data from $time_1$ and $time_2$, as opposed to say, correlations between $time_1$ and $time_3$ beyond the relationship between $time_1/time_2$ and $time_2/time_3$. It is also preferable to other related tests, such as fixed or random effects regressions, since the number of time points (11) remains small, relative to the number of cases (50).[7] I use panel regression for both of my outcomes, Medicaid spending per GDP and Medicaid spending per total social spending.

Nevertheless, I include here results from two additional tests on my primary outcome, spending per GDP, to explore robustness of this method. This is particularly useful given the limited extent to which the outcome varies over time (see descriptive results for more). The first set of models considers my variables averaged across all eleven timepoints and the second uses data from the most recent time point, 2016, with independent variables lagged one year. Both use standard OLS regression.

Models are developed to reflect the theories of welfare state development given above. First, I consider the impact of conventional functionalist and power/political variables on my primary outcome, Medicaid spending per GDP. Next, I incorporate gendered and racialized terms drawing from the power/political perspective. This is followed by a "full" model that incorporates each of these paradigms, based on earlier results. After the panel regressions, I

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[6] The command in Stata 13 is "xtpcse."
[7] Note that fixed and random effects models were run, with relatively similar results.

employ my secondary method, OLS, to examine the robustness of the panel models. These OLS regressions are conducted on the conventional and full models; additionally, parsimonious models are developed using step-wise elimination based on explanatory power of each independent variable, due to the small sample size. Third, I evaluate Medicaid spending per total social spending by building up models similar to my first set of analyses using panel regressions.

4 FINDINGS

4.1 Descriptive Results

On average, Medicaid spending comprises approximately 24% of state budgets (Figure 2.1). Descriptive statistics for both outcomes (Table 2.1), reveal that more variation exists between states, than within a given state over time. Indeed, when examining overall percentage change in both spending per GDP and total social spending over time (Figure 2.2), the slight increase is unremarkable. This finding highlights the autonomous role that the states play in setting their own healthcare policy. Nevertheless, we can notice some outliers in their averaged rate of change over time (Figure 2.3). Particularly, Maine, South Dakota, and Nebraska are the only three states to have overall a negative rate of change in spending per GDP. In addition, Texas's change in spending generosity, for both outcomes, is approximately double its next closest peer.

Figure 2.4 displays the range of spending generosity between states. Some patterns exist among Southern and Midwestern states, though spending generosity does not appear to follow the typical political patterns that commonly distinguish starkly between Southern and Northeast/West coast states. Further evidence of this variation can be seen in Figure 2.5, which shows the range of spending per GDP averaged across the 11 years alongside overall poverty levels. Here we see that those states with higher levels of poverty do not necessarily have the
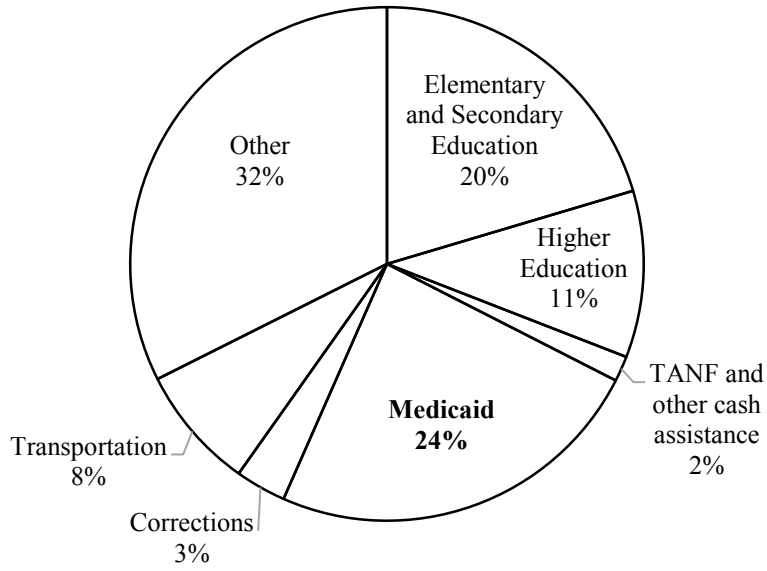
Figure 2.1 Total social spending by function (avg. 2006-2016)
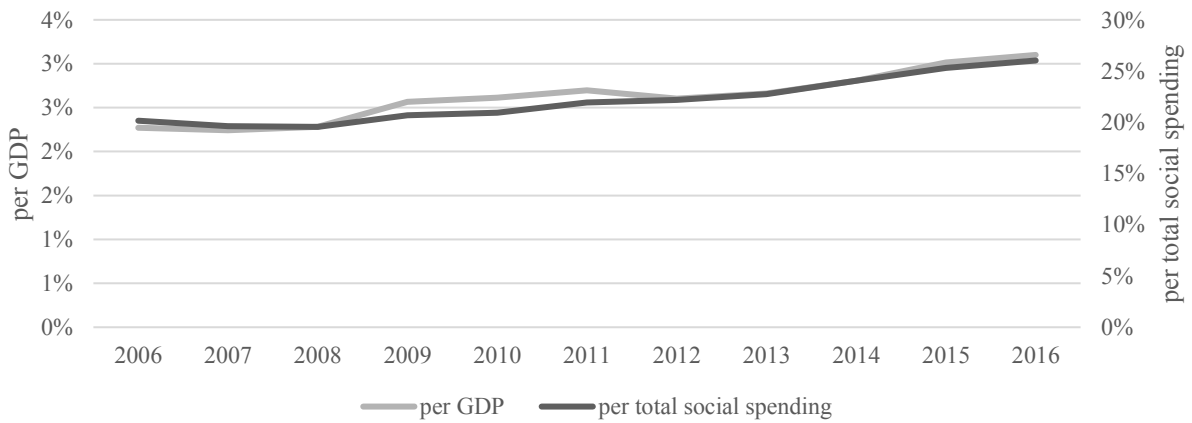
Figure 2.2 Changes in Medicaid generosity over time
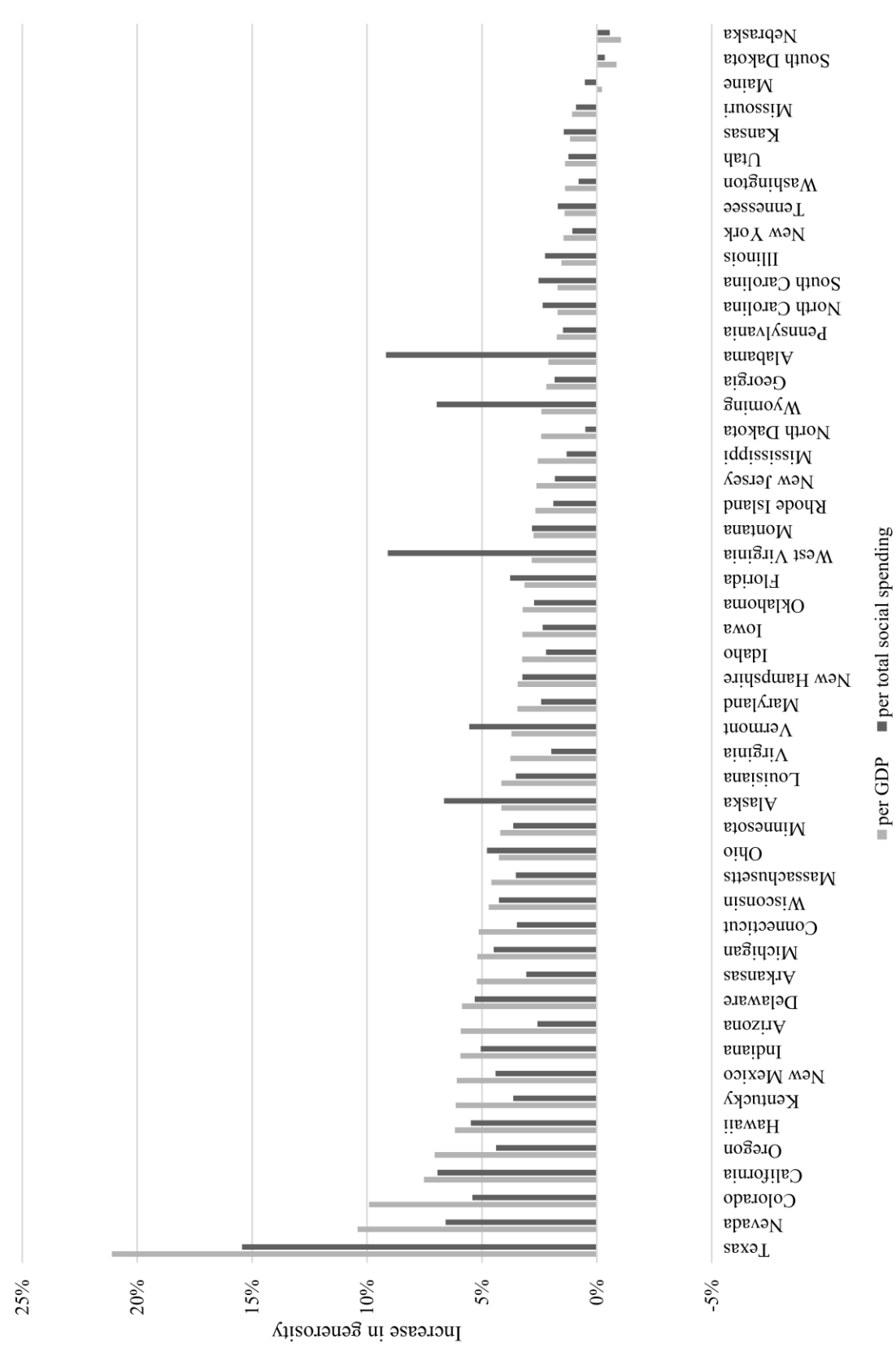
Figure 2.3 Average rate of change in Medicaid generosity, by state
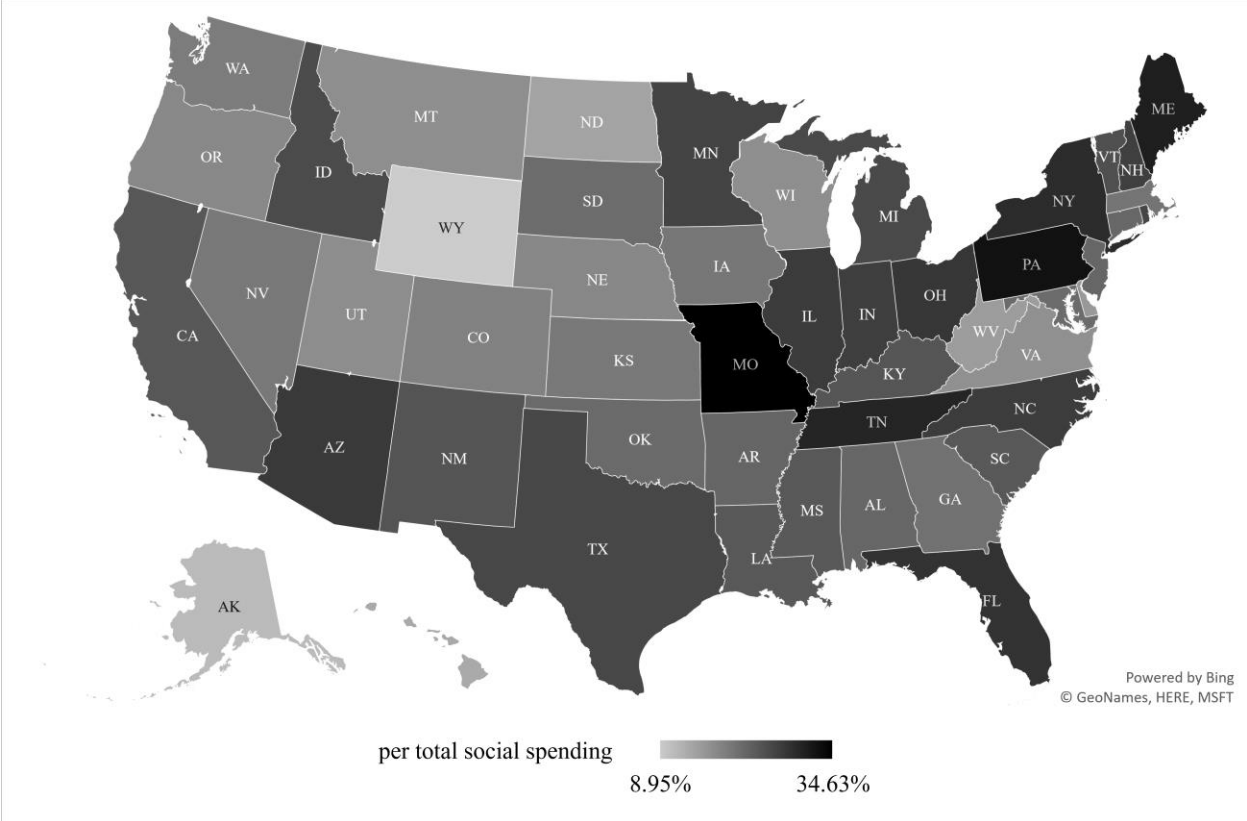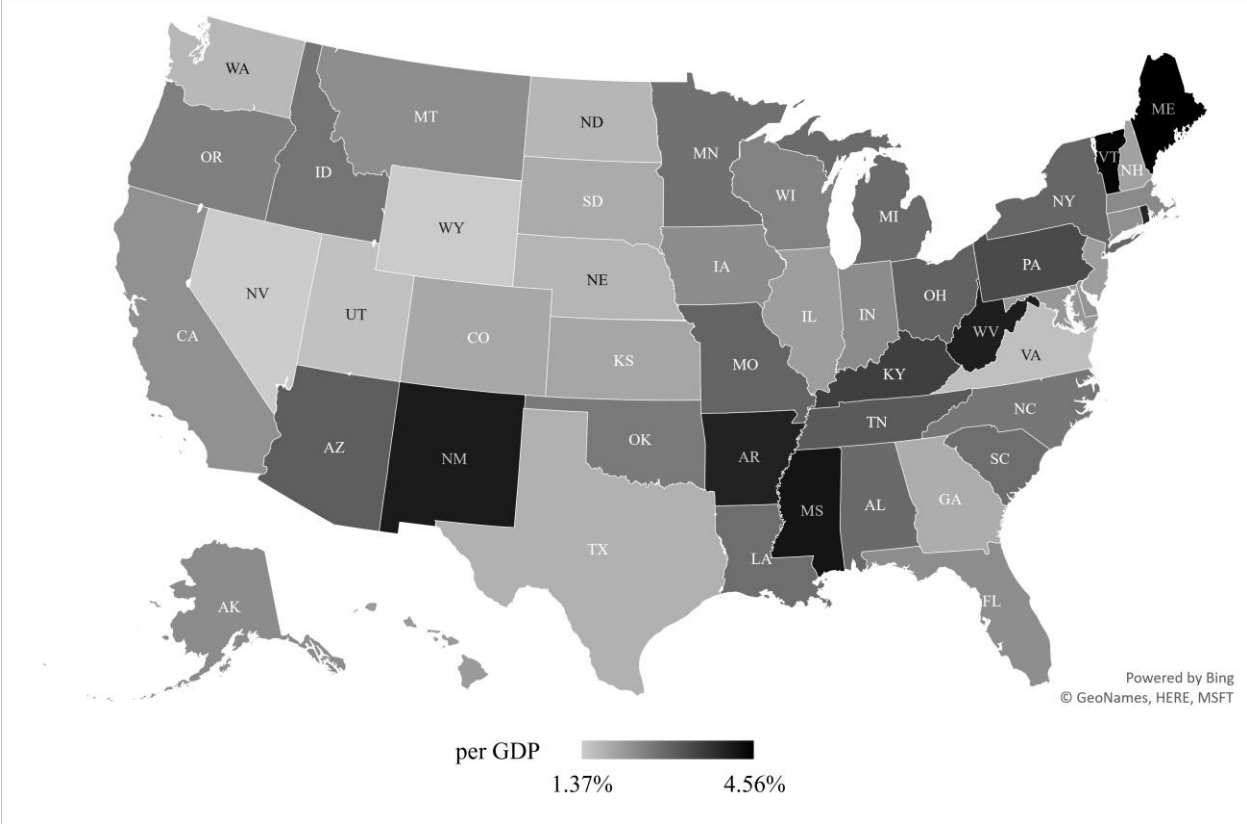
Figure 2.4 Medicaid spending generosity by state (avg. 2006-2016)
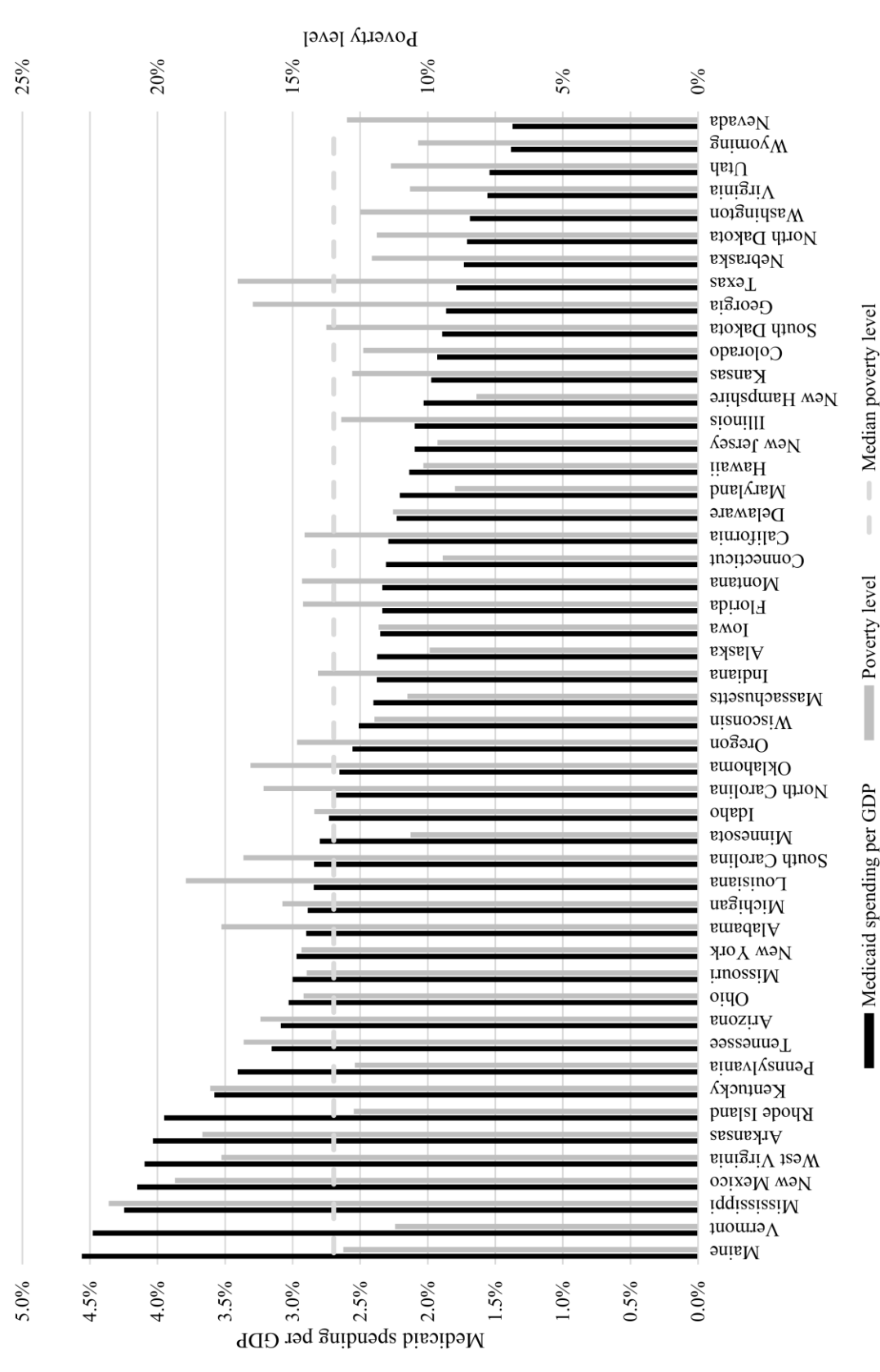
Figure 2.5 Average Medicaid spending per GDP and poverty levels, 2006-2016

most generous Medicaid spending. For example, Maine offers the most generous spending, but

its poverty level falls right below the median. In contrast, Texas exhibits relatively high poverty

levels, but falls in the bottom 20% in terms of Medicaid generosity. These can both be contrasted

with a state such as Mississippi that boasts the highest poverty level but is also ranked third in

terms of Medicaid generosity, or New Hampshire which is ranked toward the bottom in both

poverty and Medicaid spending. Based on functionalist perspectives of welfare state

development, states such as Mississippi and New Hampshire represent the expected case: high

poverty/high generosity and low poverty/low generosity, respectively (Figure 2.6). Regardless,

scatterplots reveal somewhat of a correlation between the two (Figure 2.7).

	Low generosity	High generosity
Low poverty	New Hampshire	Maine
High poverty	Texas	Mississippi

Figure 2.6 Sample state distribution for functional typology

Importantly, when poverty is disaggregated by race (Figure 2.8), we see that White poverty level

clusters more readily with Medicaid spending generosity ($r=0.551$) than does Black poverty level

($r=0.470$). As an example, we look at West Virginia in Figure 2.9 and recognize that the high

Medicaid spending generosity may be more reflective of the particularly high White poverty

levels than the Black poverty levels, which fall close to the median. This is also illustrated in

Figure 2.10, which compares White (y-axis) and Black (x-axis) poverty levels alongside

Medicaid spending generosity (bubble size). West Virginia is among the highest spenders, but

falls in the middle in terms of Black poverty levels. Compare this to Maine, which has a
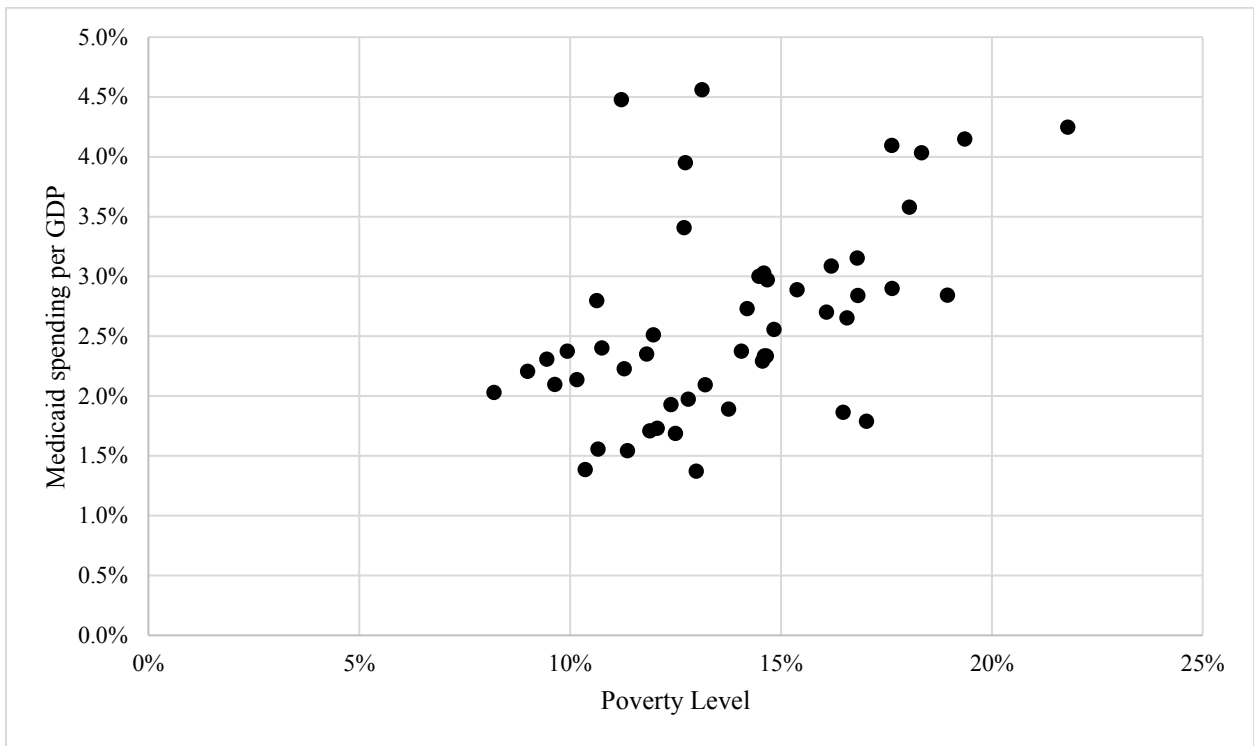
Figure 2.7 Scatterplot of Medicaid spending per GDP and poverty levels (*r*=0.5027)

✕White (r = 0.5507)   ■Black (r = 0.4698)
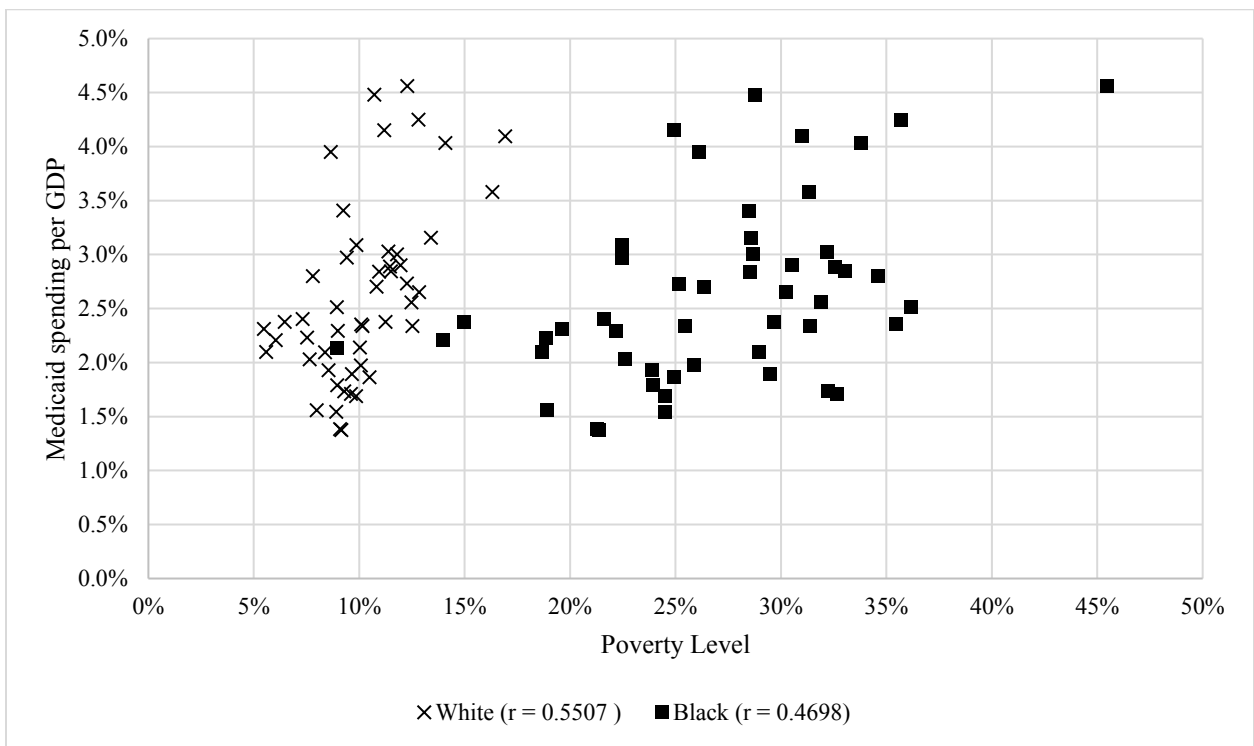
Figure 2.8 Scatterplot of Medicaid spending per GDP and poverty levels by race
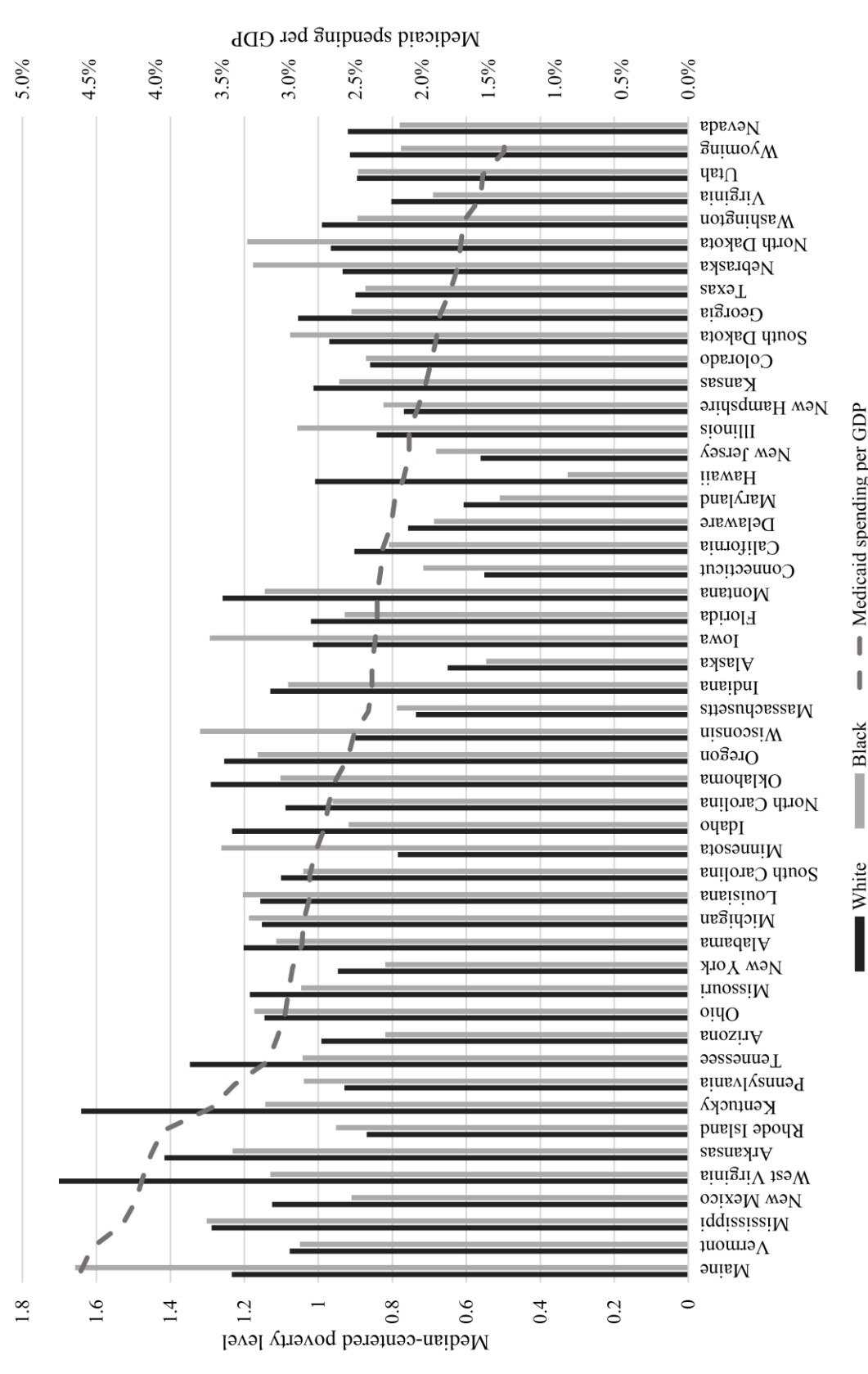
Figure 2.9 Average Medicaid spending per GDP with Median-centered poverty levels, by race

similarly generous Medicaid spending, but whose Black poverty levels are high relative to their White poverty levels. Additionally, Figures 2.8 and 2.10 highlight the overall higher levels of Black poverty in the U.S. compared to White poverty. These descriptive statistics reflect both the range of spending generosity across the states, as well as the extent to which this variation is reflective of one specific functional variable, poverty level. In addition, they highlight the differential relationship of this variable with our outcome based on the race of those experiencing poverty.
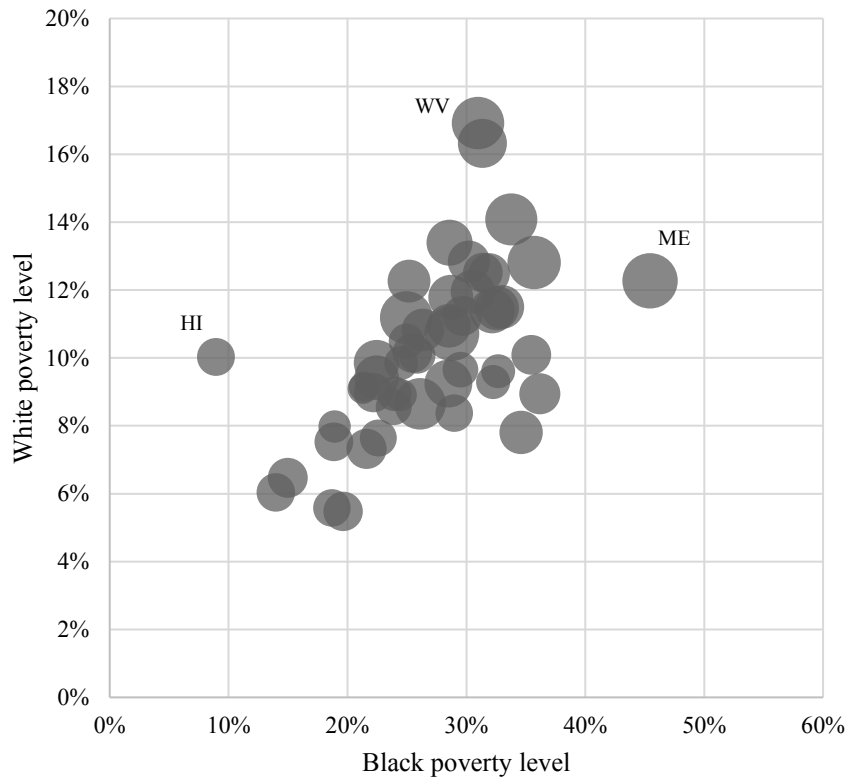
Figure 2.10 Average Medicaid spending per GDP (bubble size) by White and Black poverty levels

4.2 Medicaid Spending per GDP: Panel Regression

Moving on to inferential results, Table 2.2 shows panel regression results for conventional functional and power/political variables on *Medicaid spending per GDP*. In Model 1, which shows functional controls, we see that several of the variables have significant

associations with the outcome, and in the expected directions. *GDP per capita* is negatively associated with Medicaid spending generosity, which is consistent with GDP falling in the denominator of our generosity variable. Having a higher percent of people *under 18* is also negatively associated with Medicaid spending, which is surprising given that Medicaid funds are in part targeted toward children (Brooks et al. 2017). On the other hand, *poverty levels* are positively associated with Medicaid spending, as would be expected.

Next, Model 2 examines power and political factors on their own. Here we see that only *South* is significant, though in the opposite direction from what we would expect. Historically, the South has not supported more robust social spending; thus, it is possible that this higher generosity is reflective of need more than political intentions. Indeed, when these variables are combined with the functional controls (Model 3), the significance of *South* disappears. All of the factors from Model 1 retain their significance, and in addition we see a positive association between having an *older population* and more generous spending. Of the power/political variables, both *voter turnout* and *voter ID* laws are significant, and in the expected directions. That is, where more citizens are able to and actively engage in the political process, spending is more generous.

Table 2.3 takes these political/power variables and incorporates measures related to the gendered nature of welfare state spending. First, we see that the *gender of those experiencing poverty* does not seem to matter in overall spending generosity, as both male and female poverty are positively, significantly associated with our outcome.[8] Nonetheless, the standardized coefficient for female poverty is slightly higher than that for male poverty, though not necessarily significantly so. I also disaggregate *population by gender*, and recognize a

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[8] Male and female poverty levels are tested separately due to high correlation (0.9839). When included in the same model, neither is significantly associated with the outcome.

significant, positive association between the percent of women in a state and spending generosity. Disaggregating *voter turnout by gender* does not show any significant difference between men and women, nor does consideration of *female legislative representation*. These findings suggest that formal political processes may not be as reflective of the gendered nature of the state as are informal factors related to interest group mobilization.

Next, in Table 2.4, I disaggregate these same measures by race. Here we see that having a higher proportion of *White residents experiencing poverty* is associated with more generous spending, but the same is not true for *Black residents in poverty*.[9] When I disaggregate *population by race*, to observe the extent to which presence of any specific subgroup might drive spending, I see no significant difference. However, the direction of the coefficient is positive for White population proportion and negative for Black. As above, evaluating voter turnout does not reveal any significant differences by race.

In Table 2.5, I thus incorporate those variables that were significant in the gender and race analyses into the full model from Table 2.2. First, Model 1 examines the significant, positive association between *female representation* within the population and spending. Though this was significant among power/political factors, once functional variables are added to the model (Model 2), this significance disappears. Disaggregating *poverty by race*, on the other hand (Models 3 and 4), shows that the significant association between White poverty and spending generosity persists even once all other functional factors are added to the model. Additionally, those significant factors from Table 2.2 retain their significance here.

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[9] Including race poverty measures individually in models shows both to be significant (and positively associated), though White is at $p<0.001$ and Black is at $p<0.1$. I also included overall population proportion variables in these models and results held.

Together these results offer two main findings. First, the relevance of functional variables in shaping Medicaid policy outcomes. And second, the persistence of the role of race in mediating this political response to functional factors. In other words, there may be a relative responsiveness from the state in fulfilling the functional needs of their populace, but these efforts appear to be differentially targeted at citizens based on race.

4.3 Medicaid spending per GDP: OLS regression

In order to corroborate the robustness of my panel regressions, I repeat tests of conventional and full models using 1) data that has been averaged across the eleven time points and 2) data from the most recent year, 2016. Overall, findings support the results from the panel regressions, though results surrounding race and poverty are somewhat tempered. First, Tables 2.6 and 2.7 present models depicting the role of conventional variables in shaping spending generosity. *Poverty* is consistently significantly associated with spending, and in the same direction. While full models yield limited results particularly for power/political factors, paring down to parsimonious models shows a positive association between spending generosity and having a more *Democratic-leaning legislature* with the averaged data (Table 2.6, Model 4). With the single-year data, *voter ID laws* are significantly negatively associated, as observed in certain models above. Together, these findings again emphasize the role of functional over power/political factors when considering conventional variables on their own. This is particularly emphasized by the low r^2 values for these models in comparison to the functional ones.

When female population proportion is incorporated, results vary. Table 2.8 shows the standardized coefficients for *percent female* alongside the full model, as well as a parsimonious model, for the averaged data. Whereas in the panel regression this effect disappears, here we see

it persists in both the full and parsimonious models. The coefficient for *voter ID laws* remains significant and negative here as well. In the 2016 data (Table 2.9), however, *female population* proportion loses significance, even in the parsimonious model, as it did in the panel regression.

I incorporate *poverty disaggregated by race* as well in Tables 2.10 and 2.11. With the averaged data, White poverty levels are significantly, positively associated with the outcome, though this is only the case in the parsimonious model (3). Additionally, we see a marginally positive association with Black poverty levels as well. With the 2016 data (Table 2.11), the positive association between White poverty and spending is only marginal. Together these somewhat caution the meaningfulness of the findings from the panel regressions, that spending generosity be more reflective of White than Black needs.

4.4 Medicaid spending per total social spending

In order to capture another approach to studying Medicaid generosity, my next set of analyses consider *Medicaid spending as a proportion of total social spending* for each state-year combination. The normalization by overall social spending allows me to consider variation normalizing, or "controlling," for the extent to which a state invests in social spending at large. Results from this analysis are again based on panel regressions and can be seen in Tables 2.12-15.

First, Table 2.12 shows panel regression results for conventional functional and power/political variables. The r^2 here is similar to that for my primary dependent variable, however the precise variables which are significant differ. Specifically, we see that states with higher levels of *income inequality* spend more generously on Medicaid, as do states with *older populations*. Although none of the power/political factors are significant on their own, when

combined with functional controls we see a positive, significant association with spending generosity and *voter turnout*, as we did with the primary outcome.

Gender is incorporated into the power/political model in Table 2.13, and results are markedly similar to those from analysis of the primary outcome. *Disaggregating poverty by gender* (Models 2a-b) shows no significant difference, and in fact the standardized coefficient for women is slightly lower than that for men this time. As before, *percent female* is significantly, positively correlated with spending generosity. Neither *voter turnout* nor *female legislative representation* appears to be significant here.

When racial factors are incorporated (Table 2.14), however, results deviate from those discussed previously. In particular, disaggregating *poverty by race* (Model 2), yields opposite results to those seen when evaluating spending per GDP. That is, having a higher level of Black poverty is associated with more generous spending, while the association for White poverty is not significant. Similarly, having a higher *proportion of Black* residents in the state is also significantly, positively associated with the outcome. This would suggest that states that invest more broadly in Medicaid as a proportion of their social spending budget tend to spend more based on the needs and representation of their Black population. This contrasts with the finding from the previous panel regressions, that states with high GDP tend to spend more on Medicaid based on the needs of their White population.

The robustness of these findings is evaluated in Table 2.15, which incorporates functional controls into the significant models from Tables 2.13-14. Whereas the significant effect of *percent female* disappeared in full models with the primary outcome, here this variable retains its significance (Model 1b), and in fact we fail to see a significant association with *poverty* and spending generosity. The significance of the coefficients for *Gini coefficient*, *older population*,

and *voter turnout* (though marginal) remains. When all measures are incorporated into the evaluation of *poverty disaggregated by race* (Model 2a-b), we see the minimization of the Black poverty effect, as it remains only marginally significant. The association between spending and White poverty, though negative and non-significant in the full model, is actually positively, significantly, associated with spending when evaluated on its own alongside Black poverty levels. Finally, *population proportion by race* does not have a significant effect once all other variables are taken into account (Model 3b), though percent Black is positively, significantly associated with the outcome on its own (Model 3a).

5 DISCUSSION AND CONCLUSION

In this chapter, I examine variation in spending for Medicaid services both between states and over time, from 2006-2016. In applying theories of welfare state development, this study suggests that of conventional factors, functional arguments of state wealth and poverty are predominant in explaining variation (Figure 2.11). However, there is some support for power and political factors when gendered and racialized components are taken into consideration.
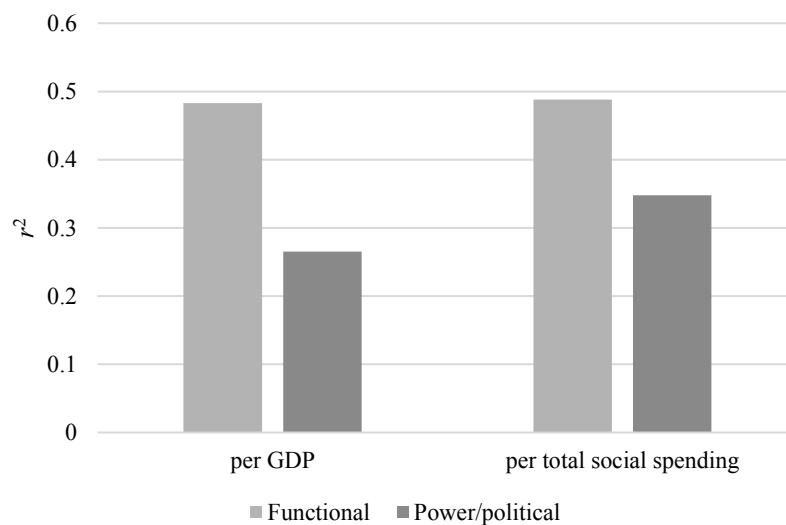
Figure 2.11 Explanatory power (r^2) of models

In particular, the distinction between the effects of poverty levels of White and Black residents on spending generosity is worth highlighting. Empirical studies (Brown 2013; Kail and Dixon 2011; Meyer 1994; Misra and Moller 1998; Moller 2002, 2002; Sander and Giertz 1986) indicate the failure of welfare policy to successfully address the needs of Black citizens, and spending for Medicaid appears to be no exception when normalized by state GDP. This is illustrated in Figure 2.12 which shows standardized panel regression coefficients for significant independent variables for the full model that disaggregates poverty by race for both outcomes. Here we see the relatively large positive effect of White poverty levels on Medicaid spending per GDP, as well as the smaller, non-significant effect of Black poverty levels. A precise mechanism for this relationship falls outside of the scope of this project, but other scholars (HoSang, LaBennett, and Pulido 2012; Omi and Winant 1986) highlight the iterative relationship between formation of racial concepts and identities and state policy. In this way, we see evidence of White privilege, in that White Americans experiencing poverty are differentially-abled to capitalize on their political powers in shaping legislation.
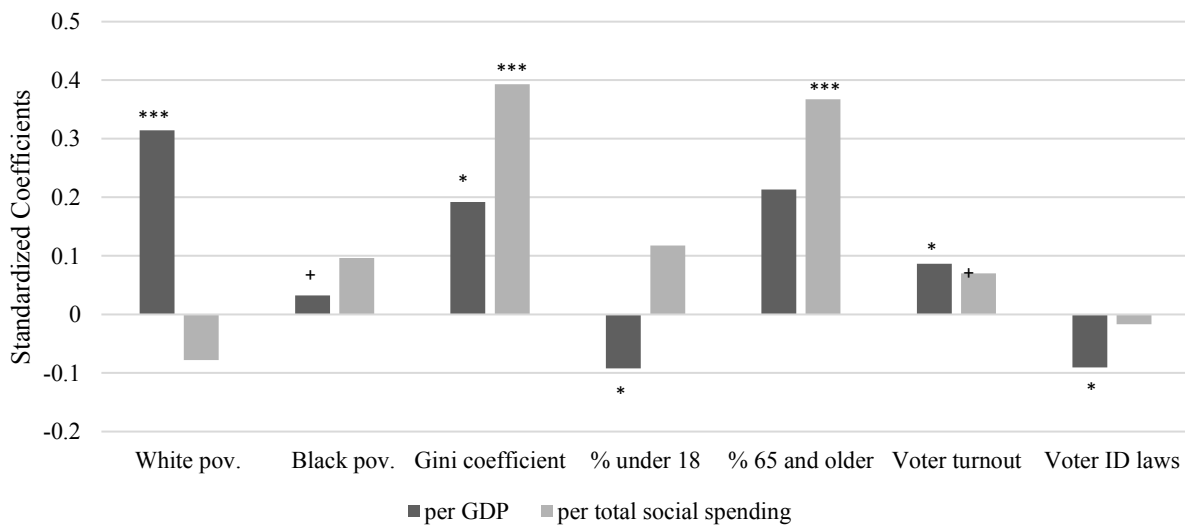
Figure 2.12 Significant standardized coefficients for full models, poverty disaggregated by race

On the other hand, when Medicaid spending is normalized by total social spending, we observe the inverse: states with higher levels of Black poverty spend significantly more generously on Medicaid, though to a lesser degree, and White poverty levels are non-significantly, negatively associated. Importantly, this finding suggests that the "power in numbers" (Blalock 1967) hypothesis may be at play with this second outcome. That is, regardless of a state's overall social spending, if there are higher percentages of Black residents experiencing poverty, more of those funds will be dedicated to Medicaid. The fact that this appears with this second specification highlights an important distinction between these two outcomes. Where a state such as Mississippi, which devotes a relatively higher portion of its GDP to Medicaid funds, might be more responsive to the needs of its White citizens, a state such as Pennsylvania, which devotes a somewhat larger portion of its total social spending budget to Medicaid, offers policy that is more reflective of the needs of Black citizens.

In addition to testing variations on my outcome, this chapter also succeeded in presenting multiple methods for approaching studies of welfare state spending. Given the nature of the data (large number of states over fewer time periods), panel regression is a standard approach to measuring variation. However, I also tested OLS regression using both averaged data as well as data from a single time point. These alternative approaches are particularly fitting given the lack of meaningful variation over time in the dataset. Though the small number of cases in the OLS regressions limited the statistical power of these approaches, results did serve to reinforce the dominant role of functional factors in shaping Medicaid spending generosity. Nonetheless, they do temper the meaningfulness of the significant findings on the racialized nature of this spending.

All told, these findings highlight the importance of incorporating both gendered and racialized perspectives into the welfare state literature, as well as of shifting a lens onto healthcare as an area of public social spending. The dominant role of functional factors in shaping spending outcomes is particularly relevant here, reflecting results from spending for other social measures, such as AFDC (see e.g. Tropman and Gordon [1978]). Yet, given the increasingly politically charged division between those who advocate for universal healthcare versus employment-based insurance, it is possible that both class power and political institution factors may play an increasing role on healthcare funding in the future. Additionally, these findings reflect the wide variety of methods and variable specifications available to scholars of the welfare state. While testing all possible iterations of these is a useful task in exploring best methodological practices, this falls outside the scope of this chapter. Nevertheless, this would be a worthwhile pursuit for future papers.

I recognize other important steps to take as I move forward with this project. First, a lack of impact from more general political factors could be due in part to my operationalization of these ideas. As referenced in Chapter 1, party preference is an overly simple mode of measuring political leanings. Incorporating measures such as those by Berry et al. (2010)[10] would be a positive next step to take. Additionally, it would be worth considering measures related more to the institutional construction of the state, such as the roles of judges in policy decision making. I also hope to incorporate the number of Medicaid recipients, as well as those eligible for these services. These values are difficult to find in a reliable, consistent manner for all of the years included in this analysis. Thus, they were not included here, but proxied for using variables

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[10] Used by political scientists, this measure of citizen and legislative ideology is developed by "using the roll call voting scores of state congressional delegations, the outcomes of congressional elections, the partisan division of state legislatures, the party of the governor, and various assumptions regarding voters and state political elites" (Berry et al. 1998:327).

related to poverty and unemployment. However, including these items, particularly if I could disaggregate them by race and/or gender, would be worthwhile. Finally, my operationalization of support for Medicaid as spending per GDP is one of many measurements for this outcome. I could, for example, consider spending per beneficiary. Furthermore, as Jacobs and Callaghan (2013) note, it may be more worthwhile to consider Medicaid expansion, or perhaps a direct analysis of the state of Medicaid before and after the implementation of the Affordable Care Act. Future studies will incorporate these other measures and test them against those discussed here.

Overall, this study serves as a small step toward discovering why spending for healthcare varies between states. Medicaid spending occupies almost a quarter of states' budget, and as such, is a good window into the nature of social spending at large. Additionally, changes in federal healthcare policy, both with the Obama and the Trump administrations, make analyses of this data particularly timely. As we see a desire from the public for continued investment in quality healthcare (Grogan and Park 2017) alongside an academic acknowledgement of healthcare as a universal right (Almgren 2017), understanding why some states readily support Medicaid spending while others are more hesitant to do so remains critical.

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Table 2.1 Descriptive statistics (N = 550)

Type	Variable	Mean	St. Dev.	Min.	Max
Outcome	Medicaid spending per GDP				
	Overall	2.62	0.90	0.50	5.80
	Between		0.83	1.37	4.56
	Within		0.38	1.34	4.28
	Medicaid spending per total social spending				
	Overall	22.11	6.26	6.61	37.72
	Between		5.48	8.95	34.63
	Within		3.11	4.21	32.08
Functional	GDP per capita	0.05	0.01	0.03	0.09
	Gini coefficient	0.45	0.02	0.41	0.51
	Unemployment rate	7.30	1.87	2.80	12.70
	% under 18	23.86	1.90	19.43	31.38
	% 65 and older	13.41	1.82	6.57	19.05
	Poverty status	13.81	3.15	7.62	22.68
Power/Political	Unionization	10.73	5.39	1.60	25.20
	Voter turnout	63.64	5.50	47.30	79.20
	Democratic gov't	1.85	1.60	0	4
	Voter ID laws	0.99	1.20	0	4
	South	0.32	0.47	0	1
Gender	Poverty by gender				
	Male	12.47	2.92	6.79	20.39
	Female	15.09	3.38	8.40	24.79
	% Female	50.64	0.76	47.62	51.79
	Voter turnout by gender				
	Male	61.52	5.54	45.20	76.70
	Female	65.63	5.68	48.20	81.70
	% Female legislature	23.88	6.95	8.80	42.00
Race	Poverty by race				
	White	10.16	2.47	4.92	17.29
	Black	26.90	6.77	5.69	48.00
	% White	71.87	15.28	22.37	95.63
	% Black	10.26	9.46	0.40	37.51
	Voter turnout by race				
	White	65.94	5.11	48.00	80.40
	Black[+]	60.62	12.08	12.50	100

✠ N = 530; see text for details.

77

Table 2.2 Panel regression of traditional variables on Medicaid spending per GDP, 2006-2016 (N = 550)

	Model 1		Model 2		Model 3	
	beta	se	beta	se	beta	se
GDP per capita	-0.20 *	(0.09)			-0.19 *	(0.09)
Gini coefficient	0.05	(0.08)			0.04	(0.08)
Unemployment rate	-0.01	(0.11)			-0.03	(0.10)
% under 18	-0.25 *	(0.10)			-0.19 *	(0.09)
% 65 and older	0.18	(0.13)			0.23 *	(0.11)
Poverty status	0.38 **	(0.12)			0.46 ***	(0.13)
Unionization			-0.10	(0.07)	0.08	(0.06)
Voter turnout			0.01	(0.05)	0.09 *	(0.04)
Democratic gov't			0.00	(0.04)	0.02	(0.03)
Voter ID laws			-0.03	(0.04)	-0.09 *	(0.04)
South			0.18 *	(0.07)	0.02	(0.06)
r^2	0.483		0.265		0.505	
rho	0.847		0.905		0.838	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

78

Table 2.3 Panel regression of gender variables on Medicaid spending per GDP, 2006-2016 (N = 550)

	Model 1		Model 2a		Model 2b		Model 3	
	beta	se	beta	se	beta	se	beta	se
Unionization	-0.098	(0.07)	0.040	(0.06)	0.050	(0.07)	-0.073	(0.06)
Voter turnout	0.010	(0.05)	0.053	(0.05)	0.055	(0.05)	-0.010	(0.05)
Democratic gov't	0.002	(0.04)	0.025	(0.04)	0.022	(0.04)	-0.001	(0.04)
Voter ID laws	-0.026	(0.04)	-0.056	(0.04)	-0.053	(0.04)	-0.024	(0.04)
South	0.177 *	(0.07)	0.065	(0.07)	0.032	(0.07)	0.089	(0.07)
Poverty by gender								
Male								
Female			0.520 ***	(0.13)	0.558 ***	(0.12)		
% Female							0.259 ***	(0.07)
Voter turnout by gender								
Male								
Female								
% Female legislature								
r^2	0.265		0.360		0.360		0.306	
rho	0.905		0.881		0.880		0.871	

Standard errors in parentheses

*** $p<0.001$, ** $p<0.01$, * $p<0.05$, + $p<0.10$

Table 2.3 *Continued*

	Model 4a		Model 4b		Model 5	
	beta	se	beta	se	beta	se
Unionization	-0.097	(0.07)	-0.099	(0.07)	-0.103	(0.07)
Voter turnout					0.008	(0.05)
Democratic gov't	0.002	(0.04)	0.002	(0.04)	-0.005	(0.04)
Voter ID laws	-0.026	(0.04)	-0.026	(0.04)	-0.025	(0.04)
South	0.178 *	(0.07)	0.177 *	(0.07)	0.187 **	(0.07)
Poverty by gender						
Male						
Female						
% Female						
Voter turnout by gender						
Male	0.008	(0.05)				
Female			0.011	(0.05)		
% Female legislature					0.058	(0.04)
r^2	0.266		0.264		0.269	
rho	0.904		0.906		0.904	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.4 Panel regression of race variables on Medicaid spending per GDP, 2006-2016 (N = 550)

	Model 1		Model 2		Model 3		Model 4[+]	
	beta	se	beta	se	beta	se	beta	se
Unionization	-0.098	(0.07)	0.046	(0.06)	-0.079	(0.07)	-0.070	(0.06)
Voter turnout	0.010	(0.05)	0.047	(0.04)	-0.004	(0.05)		
Democratic gov't	0.002	(0.04)	0.026	(0.04)	0.004	(0.04)	0.007	(0.04)
Voter ID laws	-0.026	(0.04)	-0.053	(0.04)	-0.025	(0.04)	-0.029	(0.05)
South	0.177 *	(0.07)	0.087	(0.06)	0.198 *	(0.08)	0.165 *	(0.08)
Poverty by race								
White			0.57 ***	(0.08)				
Black			0.02	(0.05)				
% White					0.05	(0.11)		
% Black					-0.03	(0.09)		
Voter turnout by race								
White							-0.02	(0.04)
Black							0.00	(0.02)
r^2	0.265		0.397		0.282		0.298	
rho	0.905		0.850		0.884		0.874	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

+ N = 530 due to availability of Black voter data

Table 2.5 Panel regression of all variables on Medicaid spending per GDP, 2006-2016 (N = 550)

	Model 1		Model 2		Model 3		Model 4	
	beta	se	beta	se	beta	se	beta	se
% Female	0.300 ***	(0.057)	0.030	(0.090)				
Poverty status			0.498 ***	(0.120)				
White					0.534 ***	(0.074)	0.315 ***	(0.077)
Black					0.049	(0.054)	0.033	(0.051)
GDP per capita			-0.186 **	(0.085)			-0.188	(0.091)
Gini coefficient			-0.006 +	(0.103)			0.192 *	(0.067)
Unemployment rate			-0.021 +	(0.101)			0.040	(0.097)
% under 18			-0.214 +	(0.077)			-0.092 *	(0.078)
% 65 and older			0.195	(0.106)			0.214	(0.100)
Unionization			0.109	(0.061)			0.046	(0.059)
Voter turnout			0.074 +	(0.042)			0.086 *	(0.044)
Democratic gov't			0.023	(0.033)			0.021	(0.031)
Voter ID laws			-0.095 *	(0.038)			-0.091 *	(0.040)
South			0.019	(0.052)			0.051	(0.052)
r^2	0.306		0.524		0.398		0.505	
rho	0.859		0.797		0.825		0.827	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.6 OLS regression of traditional variables on Medicaid spending per GDP, 3-year avg. (N = 50)

	Model 1			Model 2			Model 3			Model 4		
	beta		se	beta		se	beta		se	beta		se
GDP per capita	-0.24		(0.18)				-0.32	+	(0.17)	-0.30	+	(0.16)
Gini coefficient	-0.16		(0.16)				-0.13		(0.15)			
Unemployment rate	0.12		(0.17)				0.02		(0.19)			
% under 18	-0.50	*	(0.22)				-0.36		(0.22)	-0.37	***	(0.10)
% 65 and older	-0.07		(0.24)				-0.04		(0.22)			
Poverty status	0.46	*	(0.18)				0.51	**	(0.19)	0.41	***	(0.11)
Unionization				-0.05		(0.16)	0.17		(0.14)			
Voter turnout				-0.08		(0.16)	0.01		(0.11)			
Democratic gov't				0.19		(0.22)	0.03		(0.20)			
Voter ID laws				-0.13		(0.19)	-0.21		(0.15)	-0.25	*	(0.10)
South				0.22		(0.16)	0.06		(0.12)			
r^2	0.528			0.113			0.594			0.558		

Standard errors in parentheses
*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.7 OLS regression of traditional variables on Medicaid spending per GDP, 2016. (N = 50)

	Model 1		Model 2		Model 3		Model 4	
	beta	se	beta	se	beta	se	beta	se
GDP per capita	-0.30	(0.23)			-0.45 +	(0.24)	-0.40 **	(0.15)
Gini coefficient	-0.17	(0.24)			-0.12	(0.24)		
Unemployment rate	-0.08	(0.20)			-0.24	(0.22)		
% under 18	-0.73 **	(0.27)			-0.55 *	(0.24)	-0.31 *	(0.12)
% 65 and older	-0.28	(0.33)			-0.28	(0.31)		
Poverty status	0.64 *	(0.27)			0.79 **	(0.26)	0.49 **	(0.16)
Unionization			0.04	(0.25)	0.16	(0.22)		
Voter turnout			-0.10	(0.19)	-0.04	(0.11)		
Democratic gov't			0.11	(0.19)	0.27	(0.19)	0.37 *	(0.14)
Voter ID laws			-0.10	(0.18)	-0.14	(0.12)		
South			0.22	(0.20)	-0.05	(0.16)		
r^2	0.448		0.065		0.547		0.488	

Standard errors in parentheses
*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.8 OLS regression of gender variables on Medicaid spending per GDP, 3-year avg. (N = 50)

	Model 1			Model 2			Model 3		
	beta		se	beta		se	beta		se
% Female	0.409	**	(0.121)	0.364	*	(0.164)	0.369	**	(0.122)
GDP per capita				-0.209		(0.167)			
Gini coefficient				-0.362	*	(0.162)	-0.450	**	(0.129)
Unemployment rate				-0.085		(0.192)			
% under 18				-0.411	+	(0.237)	-0.302	**	(0.108)
% 65 and older				-0.182		(0.238)			
Poverty status				0.694	**	(0.199)	0.802	***	(0.109)
Unionization				0.234	+	(0.132)	0.195	*	(0.094)
Voter turnout				-0.046		(0.100)			
Democratic gov't				-0.055		(0.203)			
Voter ID laws				-0.219		(0.138)	-0.190	*	(0.091)
South				-0.009		(0.116)			
r^2			0.197			0.637			0.617

Standard errors in parentheses
*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.9 OLS regression of gender variables on Medicaid spending per GDP, 2016 (N = 50)

	Model 1			Model 2			Model 3		
	beta		se	beta		se	beta		se
% Female	0.31	*	(0.15)	0.20		(0.24)	-0.12		(0.18)
GDP per capita				-0.40	+	(0.23)	-0.40	**	(0.15)
Gini coefficient				-0.27		(0.24)			
Unemployment rate				-0.30		(0.23)			
% under 18				-0.59	*	(0.25)	-0.36	**	(0.12)
% 65 and older				-0.37		(0.29)			
Poverty status				0.90	**	(0.26)	0.54	**	(0.17)
Unionization				0.20		(0.22)			
Voter turnout				-0.08		(0.11)			
Democratic gov't				0.25		(0.18)	0.382	*	(0.15)
Voter ID laws				-0.14		(0.12)			
South				-0.10		(0.17)			
r^2			0.080			0.557			0.495

Standard errors in parentheses
*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.10 OLS regression of race variables on Medicaid spending per GDP, 3-year avg. (N = 50)

	Model 1 beta	Model 1 se	Model 2 beta	Model 2 se	Model 3 beta	Model 3 se
Poverty status						
White	0.40 ***	(0.10)	0.08	(0.21)	0.37 ***	(0.09)
Black	0.22 +	(0.13)	0.28	(0.19)	0.20 +	(0.10)
GDP per capita			-0.31	(0.18)	*	
Gini coefficient			0.01	(0.14)		
Unemployment rate			0.20	(0.20)	0.31	(0.12)
% under 18			-0.28	(0.25)	-0.26	(0.10)
% 65 and older			-0.07	(0.25)		
Unionization			0.07	(0.14)		
Voter turnout			-0.15	(0.19)		
Democratic gov't			0.08	(0.23)		
Voter ID laws			-0.18	(0.15)	-0.19	(0.12)
South			0.10	(0.13)		
r^2		0.339		0.569		0.516

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.11 OLS regression of race variables on Medicaid spending per GDP, 2016 (N = 50)

	Model 1 beta	Model 1 se	Model 2 beta	Model 2 se	Model 3 beta	Model 3 se
Poverty status						
White	0.54 ***	(0.14)	0.14	(0.20)	0.28 +	(0.15)
Black	0.09	(0.14)	0.26	(0.18)	0.15	(0.12)
GDP per capita			-0.58	(0.30)	-0.43 +	(0.20)
Gini coefficient			0.10	(0.23)		
Unemployment rate			0.05	(0.25)		
% under 18			-0.41	(0.28)	-0.22	(0.12)
% 65 and older			-0.28 +	(0.36)	*	
Unionization			0.03	(0.23)		
Voter turnout			-0.16	(0.17)		
Democratic gov't			0.30 +	(0.18)	0.35 *	(0.13)
Voter ID laws			-0.11	(0.15)		
South			0.01	(0.17)		
r^2		0.273		0.488		0.441

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.12 Panel regression of traditional variables on Medicaid spending per total social spending, 2006-2016 (N = 550)

	Model 1		Model 2		Model 3	
	beta	se	beta	se	beta	se
GDP per capita	-0.12	(0.08)			-0.12	(0.08)
Gini coefficient	0.37 ***	(0.08)			0.40 ***	(0.07)
Unemployment rate	0.12	(0.08)			0.12	(0.07)
% under 18	0.15	(0.10)			0.13	(0.09)
% 65 and older	0.40 ***	(0.09)			0.38 ***	(0.08)
Poverty status	-0.04	(0.10)			-0.02	(0.11)
Unionization			-0.11	(0.08)	-0.05	(0.06)
Voter turnout			0.00	(0.05)	0.09 *	(0.04)
Democratic gov't			-0.04	(0.04)	-0.04	(0.04)
Voter ID laws			0.02	(0.05)	-0.03	(0.05)
South			0.04	(0.09)	-0.07	(0.07)
r^2	0.488		0.348		0.494	
rho	0.820		0.877		0.822	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.13 Panel regression of gender variables on Medicaid spending per total social spending, 2006-2016 (N = 550)

	Model 1		Model 2a		Model 2b	
	beta	se	beta	se	beta	se
Unionization	-0.114	(0.08)	-0.020	(0.08)	-0.027	(0.08)
Voter turnout	0.003	(0.05)	0.047	(0.04)	0.044	(0.04)
Democratic gov't	-0.041	(0.04)	-0.024	(0.04)	-0.028	(0.04)
Voter ID laws	0.021	(0.05)	-0.003	(0.05)	0.001	(0.05)
South	0.035	(0.09)	-0.066	(0.10)	-0.082	(0.10)
Poverty by gender						
Male						
Female			0.432 ***	(0.10)	0.417 ***	(0.10)
% Female						
Voter turnout by gender						
Male						
Female						
% Female legislature						
r^2	0.348		0.360		0.360	
rho	0.877		0.883		0.887	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.13 *Continued*

	Model 3		Model 4a		Model 4b	
	beta	se	beta	se	beta	se
Unionization	-0.111	(0.07)	-0.115	(0.08)	-0.117	(0.08)
Voter turnout	-0.012	(0.05)			-0.001	(0.05)
Democratic gov't	-0.056	(0.04)	-0.041	(0.04)	-0.049	(0.04)
Voter ID laws	0.032	(0.05)	0.022	(0.05)	0.025	(0.05)
South	-0.126	(0.09)	0.033	(0.09)	0.045	(0.08)
Poverty by gender						
Male						
Female						
% Female	0.432 ***	(0.07)				
Voter turnout by gender						
Male			-0.035	(0.06)		
Female			0.038	(0.05)		
% Female legislature					0.057	(0.05)
r^2	0.306		0.264		0.269	
rho	0.863		0.876		0.866	

Standard errors in parentheses

*** $p<0.001$, ** $p<0.01$, * $p<0.05$, + $p<0.10$

Table 2.14 Panel regression of race variables on Medicaid spending per total social spending, 2006-2016 (N = 550)

	Model 1		Model 2		Model 3		Model 4[+]	
	beta	se	beta	se	beta	se	beta	se
Unionization	-0.114	(0.08)	-0.097	(0.08)	-0.105	(0.08)	-0.105	(0.07)
Voter turnout	0.003	(0.05)	-0.001	(0.05)	0.007	(0.05)		
Democratic gov't	-0.041	(0.04)	-0.033	(0.04)	-0.039	(0.04)	-0.043	(0.03)
Voter ID laws	0.021	(0.05)	0.022	(0.05)	0.014	(0.05)	0.026	(0.05)
South	0.035	(0.09)	0.027	(0.09)	-0.045	(0.10)	0.033	(0.09)
Poverty by race								
White			0.012	(0.02)				
Black			0.098 *	(0.05)				
% White					-0.025	(0.12)		
% Black					0.169 *	(0.08)		
Voter turnout by race								
White							-0.028	(0.05)
Black							-0.018	(0.04)
r^2	0.348		0.355		0.349		0.382	
rho	0.877		0.877		0.881		0.841	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

+ N=530 due to availability of Black voter data

Table 2.15 Panel regression of all variables on Medicaid spending per total social spending, 2006-2016 (N = 550)

	Model 1a		Model 1b		Model 2a	
	beta	se	beta	se	beta	se
% Female	0.38 ***	(0.07)	0.17 *	(0.07)		
Poverty status						
White			0.03	(0.11)	0.31 **	(0.10)
Black					0.06	(0.06)
% White						
% Black						
GDP per capita			-0.08	(0.08)		
Gini coefficient			0.32 ***	(0.09)		
Unemployment rate			0.10	(0.08)		
% under 18			0.14 +	(0.09)		
% 65 and older			0.36 **	(0.09)		
Unionization			-0.03	(0.07)		
Voter turnout			0.08 +	(0.04)		
Democratic gov't			-0.05	(0.04)		
Voter ID laws			-0.02	(0.05)		
South			-0.11	(0.07)		
r^2	0.370		0.499		0.360	
rho	0.876		0.819		0.882	

Standard errors in parentheses
*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 2.15 *Continued*

	Model 2b beta	se	Model 3a beta	se	Model 3b beta	se
% Female					-0.07	(0.10)
Poverty status						
White	-0.08	(0.09)				
Black	0.10 +	(0.05)				
% White			-0.002	(0.11)	0.09	(0.08)
% Black			0.19 **	(0.06)	-0.07	(0.07)
GDP per capita	-0.13	(0.08)			-0.14 +	(0.08)
Gini coefficient	0.39 ***	(0.06)			0.47 ***	(0.08)
Unemployment rate	0.12	(0.07)			0.16 *	(0.08)
% under 18	0.12	(0.08)			0.15 *	(0.08)
% 65 and older	0.37 ***	(0.08)			0.35 ***	(0.08)
Unionization	-0.03	(0.06)			-0.04	(0.06)
Voter turnout	0.07 +	(0.04)			0.09 *	(0.04)
Democratic gov't	-0.04	(0.04)			-0.05	(0.04)
Voter ID laws	-0.02	(0.05)			-0.02	(0.04)
South	-0.06	(0.06)			-0.03	(0.07)
r^2	0.504		0.346		0.508	
rho	0.803		0.878		0.784	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

CHAPTER 3

PUBLIC EXPENDITURES AND NEED FOR FAMILY PLANNING SERVICES

1 INTRODUCTION

The United States has long been considered an outlier in its extent and quality of welfare services; legislation offering support for reproductive healthcare is no exception. At the same time that we see an increasing need for publicly funded access to these services (Frost, Frohwirth, and Zolna 2016; Frost, Zolna, and Frohwirth 2013), reports indicate concern over recent or anticipated changes in the landscape of reproductive healthcare (Gold and Hasstedt 2017; Kreitzer and Smith 2016). Notably, these changes affect women of color and those experiencing poverty particularly poorly (Hasstedt 2017; Howell and Starrs 2017). With the exception of a small handful of federal regulations, the protection of women's rights to healthcare remains relegated to the states. As such, we see a patchwork of provisions developed haphazardly within the varying cultural and historical contexts of each state. In this chapter, I ask: What state-level factors are associated with variation in spending for reproductive healthcare services? And how do historical policies, along with women's needs for these services, impact levels of spending?

To answer these questions, given an understanding of the role that the state as an institution plays in shaping collective notions of gender (MacKinnon 1989; Martin 2004) and race (Omi and Winant 1986), I draw from literature on the gendered and racialized welfare state. Building off of work by Marshall (1950) and Rawls (1971), Almgren (2017) highlights the extent to which healthcare can and should be a right of citizenship in a wealthy democracy. Similarly, Daniels (1993) and Orloff (1993) emphasize the right to bodily autonomy as a

"primary foundation of liberal citizenship" (Daniels 1993:5). The argument for including

spending on reproductive health in discussions of social rights is strengthened when we consider

the positive impacts experienced by women, and society as a whole, when these services are

more readily accessible (Frost et al. 2014; Frost, Finer, and Tapales 2008; Kavanaugh and

Andersen 2016).

Yet path-dependent histories of gender and racial injustices surrounding reproductive

policy complicate this right. In particular, much scholarship is dedicated to documenting the use

of family planning policy as a method of state control over women's bodies, particularly for

women of color and women experiencing poverty (Correa and Reichmann 1994; Farrell,

Dawkins, and Oliver 1983; Greil et al. 2011; Gurr 2011; King and Meyer 1997; Roberts 2014).

More broadly, other scholars note the two-tiered nature of U.S. social welfare in general (Gordon

1994; Quadagno 1996; Sainsbury 1996; Schram, Soss, and Fording 2003) that disproportionately

stigmatizes women and people of color.

This chapter thus serves as an empirical examination of the impact that the racialized and

gendered welfare state has on shaping reproductive policy outcomes. Specifically, I use OLS

regression to predict generosity of spending for family planning services (contraceptives,

sterilization, and associated services) based on a variety of state level factors at three recent time-

points: 2006, 2010, and 2015. Data is gathered from publicly available sources, such as reports

from the Guttmacher Institute, the U.S. Census Bureau, and the U.S. Bureau of Economic

Analysis.

This chapter contributes to my larger investigation into gendered and racialized policy

mechanisms in two ways. First, in conducting an empirical analysis of variation in spending for

reproductive services, I am applying traditional theories of welfare state development to an

under-studied form of social spending in the welfare state literature, spending for family planning services. Second, I am advocating for the incorporation of measures related to the racialized and gendered nature of these policies.

2 THEORY

Scholarship and reports (Almeling 2015; Center for Reproductive Rights 2011) make a compelling case for treating reproductive healthcare as a social right of citizenship. In this way, the theories of welfare state development addressed previously in Chapters 1 and 2 serve as a useful jumping off point in examining spending for family planning services. Furthermore, given the inherently gendered aspect of family planning services, alongside a particularly racialized history even within the context of the racialized U.S. welfare state, attention to race and gender makeup of both the population and those in need is particularly important. A summary of the hypotheses developed in Chapter 1 can again be seen in Table 1.1.

As described in previous chapters, conventional theories of welfare state development can be classified as falling into two categories. First, functionalists argue that state spending is based upon both the state's need for publicly-funded services as well as its capacity to support this need (Cutright 1965; Wilensky 1975). We thus expect that states with higher wealth would spend more generously, as would states with higher levels of poverty and unemployment, and similarly higher levels of income inequality (*H1*). Other functionalist variables, such as population age, primarily serve as controls against which more theoretically-motivated variables are tested.

Next, scholars identify a series of variables that speak to the political institution of the state (Amenta 1998) as well as citizens' abilities to capitalize on their political rights (Korpi

1989; Misra 2002; Quadagno 1987; Skocpol and Amenta 1986). These include factors such as

levels of unionization, voter engagement and party identification, as well as specific policies

related to voting access and prior legislative actions (Quadagno 2004; Skocpol and Amenta

1986). In incorporating these conventional aspects of the welfare state literature into my analysis,

I expect that states with more liberal policy and policy-makers (*H3*), as well as better access to

political rights via strong unions and lack of voter ID laws (*H2*) will spend more generously for

family planning services.

2.1 Gender, Race, and Family Planning Services

Scholars of the gendered welfare state point to the importance of studying funding

allocations of particular relevance to women (Bacchi 1999; Lewis 1992; O'Connor, Orloff, and

Shaver 1999; Orloff 1996; Sainsbury 1996) in order to more fully capture the extent to which a

state supports its populace. Studying spending generosity for reproductive healthcare services

specifically, I am able to evaluate policies targeted to woman-as-citizen, rather than woman-as-

mother. Additionally, these scholars also highlight the importance of considering predictive

factors that take into account women's experiences rather than considering purportedly gender-

neutral variables, such as overall poverty level. I thus incorporate a series of additional

independent variables in this analysis related to the theoretical frames described above. First,

given the higher rates at which women experience poverty within the U.S. (Pearce 1978) as well

as the inherently gendered nature of my outcome, looking at overall poverty levels may not tell

the full story of the extent to which policy is reflective of women's needs. I thus anticipate that

high female poverty levels will be associated with more generous spending, moreso than male

poverty levels (*H4*). Similarly, I include a factor related specifically to need for publicly funded

contraceptives among women. Additionally, the extent to which class power, in particular voter participation and female representation, impact such a gendered outcome may be mediated in part by gender. Under the expectation that citizens are voting in self-interest, I would expect that high female voter participation as well as a larger population proportion of women would be positively correlated with family planning spending (*H4*).

Second, feminist scholars of the welfare state also emphasize the role of female representation within the legislature in advocating for and passing legislation related to women's fights for equality (Bolzendahl and Brooks 2007; Paxton, Green, and Hughes 2008; Poggione 2004). Thus, I expect that states legislatures that have a higher proportion of women will also spend more generously on publicly funded family planning services (*H5*).

Just as welfare spending at large carries a racialized history, so too do policies aimed at family planning services. Scholars have detailed the history of family planning policies used as a means for controlling the reproductive outcomes for women of color (Correa and Reichmann 1994; Farrell et al. 1983; Greil et al. 2011; Gurr 2011; King and Meyer 1997; Roberts 2014). Simultaneously, we recognize that those who are most underserved by current family planning policy tend to be poorer women and women of color (Center for Reproductive Rights 2011). This reflects the "too much/too little" dilemma espoused by Joffe (2018), and Joffe and Reich (2014) or the "contraceptive paradox" described by Mann (2018). Thus, a question emerges about the extent to which current funding policies may or may not support the needs of women of color equally to white women's needs. From a historical perspective, we might expect higher levels of public funding for family planning services in areas with relatively higher poverty and need among Black women; yet given current descriptive reports, we indeed anticipate seeing the opposite. This is further suggested by scholars of the racialized welfare state who highlight the

role that racial representation may play in shaping spending outcomes. In particular, scholars

offer the "threat hypothesis" (Key 1949) which suggests that the presence of people of color

within a state will cause fear among White policy-makers who will in turn produce policies that

fail to help, or explicitly harm, people of color.[1] Similarly, racialized conflict theory (Brown

2013) and critical race theory (Delgado and Stefancic 2012) indicate the extent to which state

policy is shaped by, and to protect, those in power or in the majority, i.e. White Americans.

Thus, in considering the percent of a state's population that is Black and White, alongside female

poverty levels and need disaggregated by race, we anticipate that state spending will be more

reflective of White women's needs and representation than those of Black women (*H6*).

3 DATA AND METHODS

The variables selected for this chapter are based on those used in previous literature, as

detailed above. Descriptive statistics for all variables can be seen in Table 3.1.

3.1 Data

Data for this chapter come from a variety of publicly available sources, including the

U.S. Census Bureau and the U.S. Bureau of Economic Analysis. Data for spending on family

planning comes from public reports published by the Guttmacher Institute. The Guttmacher

Institute is a private organization that collects data on, and advocates for, sexual and reproductive

health. Data for this project come from the results of the 2006, 2010, and 2015 surveys of public

expenditures (Hasstedt, Sonfield, and Benson Gold 2017; Sonfield, Alrich, and Gold 2008;

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[1] This is contrasted with the "power in numbers" hypothesis, which highlights the positive role that representation can play in making change. Debates surrounding these opposing theories suggest the extent to which both may be at play, indeed in non-linear fashions (Reese, Ramirez, and Estrada-Correa 2013). Given the data available for this project, that type of nuanced analysis falls outside the scope of this project, but is recommended for future research.

Sonfield and Gold 2012). Conducted at seven time points since 1980, this survey gathers state-level data from a series of healthcare providers regarding expenditures, by funding source, for contraceptives, sterilization, abortion, and related services. Data collection itself took place across the span of approximately 6 months to one year (depending on the year) via email and telephone. Surveys were administered to "to the health, social services and Medicaid agencies in all 50 states and the District of Columbia, as well as to … Title X grantees that were identified by the federal Office of Population Affairs" (Hasstedt et al. 2017). Missing data were filled in using reports from previous years, as well as Title X grant information from the Office of Population Affairs and Medicaid and Children's Health Insurance Program (CHIP) expenditures from Centers for Medicare and Medicaid Services (CMS). More detailed data collection methodology can be found in the reports themselves. These specific years were chosen for their recency and availability of relevant data; future projects would do well to examine additional years as well. The analytic sample for analysis is comprised of data from all fifty states but excludes D.C.[2] (N = 50).

Although valid, reliable data on reproductive services is notably difficult to collect, the nature and source of the data used for this analysis circumvent some of these difficulties. Specifically, aggregated public spending data is of a less sensitive nature than individual-level data indicating use of family planning services and is thus less likely to be subject to certain report biases. Additionally, since data come from service providers, rather than individual self-reports, the threat of social desirability is again minimized. One major concern regarding reliability of these reports is inconsistent response rates between organizations, states, and years. To address this, authors used additional data from the Office of Population Affairs and the

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[2] D.C. is excluded from the analytic sample in part due to data availability for other measures, and in part because of its exceptional political status (e.g. failing to have its own legislative or executive body outside of Congress).

Center for Medicare and Medicaid services as appropriate. Authors caution that "the report[s] should be seen as providing an approximation, rather than a precise accounting, of dollars spent" (Hasstedt et al. 2017). Nevertheless, this data "represent[s] the most complete summary of public funding available" (Hasstedt et al. 2017) and thus application of these results are appropriate here.

3.1.1 Dependent Variable

This chapter considers two conceptualizations of my outcome, family planning spending generosity. The first dependent variable is a measure of spending for *family planning services as a proportion of state gross domestic product* (GDP) for the same year. The second considers *family planning spending per total social spending* in order to target a slightly different perspective on spending generosity. As defined by the Guttmacher Institute, family planning "refer[s] to the package of direct patient care services provided through family planning programs to clients receiving reversible contraceptives or sterilization services" (Sonfield and Gold 2012). These include client counseling and education, contraceptive drugs and devices, related diagnostic tests and treatment after diagnosis. Surveys prior to 2015 distinguish between contraceptive and sterilization expenditures, but the survey in 2015 did not. Thus, here I keep these types of expenditures combined, yet notably they represent different services at both an individual and societal levels, particularly when considering disproportional sterilization rates among women of color (Borrero et al. 2014; Ramsden 2003). Disentangling these two using earlier data would provide nuance to this exploration in future research. In addition, notably, these values do not include funding for abortion services.[3]

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[3] See Chapter 4 for analysis of policy for publicly funded abortions.

In analyses of state spending and welfare development, a variety of outcomes have been considered, depending on the goal of the analysis (Olaskoaga-Larrauri, Aláez-Aller, and Díaz-de-Basurto 2010). Here I have chosen to primarily normalize spending by state wealth in order to speak to the extent of welfare development as it refers to family planning spending, and to be consistent with other scholars. From Bolzendahl (2009), "Placing GDP in the denominator reflects these priorities in relative terms, recognizing that states may vary in terms of overall economic productivity and thus standardizes spending within a particular nation [or state]." Nevertheless, I also normalize family planning spending by overall total social spending in order to 1) conduct a robustness check on my primary outcome and 2) investigate the extent to which states that invest in social spending at large are particularly responsive of the need for family planning services.

Additionally, given the vast extent to which medical care is privatized in the U.S., it is worth noting the availability of these services through private avenues (such as employee-based insurance). However, its exclusion from measures used here is appropriate. In considering extent of welfare state development, as represented by spending for family planning, I am concerned only with those goods provided by the state, to the extent that they confer rights of citizenship (Almgren 2017). An analysis of total (public and private) spending for family planning would speak more to considerations of use and coverage of these services by and for citizens. Although this is an equally worthwhile endeavor, it remains outside the scope of this paper.

3.1.2 Independent variables

Independent variables used in this analysis are based on those from previous studies of welfare spending in the U.S., with special attention to those that take race and gender into

account (e.g. Kail and Dixon [2011], Misra and Moller [1998], and Moller [2002]). In annual

models, independent variables are lagged one year, except where otherwise noted; averaged

models evaluate data from 2006, 2010, and 2015, averaged together.

The first set of independent variables speaks to a functionalist perspective of welfare state

development, considering states' needs for these services alongside their ability to provide for

them. To account for a states' abilities to provide funding for these services, I include a control

for state *GDP per capita* as well as *Gini coefficient*. GDP per capita is in millions of dollars, and

is adjusted for inflation in the averaged models. The Gini coefficient ranges from 0 to 1, with

higher values indicating higher levels of inequality. To capture need within a state, I include a

series of *poverty* and *unemployment levels* alongside controls for *population age*.

Next, I include several variables from the power and political perspectives in order to

capture the extent to which these functional factors are tempered by citizen engagement and

access to political rights. First is a measure of the extent of *unionization* that exists within the

state, that is, the percent of those who are employed that are members of unions. I also include

percent of citizens who *voted* in the previous presidential election, disaggregated by gender and

race. Second, to identify the dominant political party within the state I develop a five-point scale

measuring the extent to which *state government is Democratic* vs. Republican. This measure

incorporates both legislative majority and gubernatorial party affiliation.[4] Third, I add a scale

indicating a state's lack of strict voter ID laws, where lower values reflect stricter laws. This

categorization is developed by the National Council of State legislatures and reflects whether a

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[4] Specifically: 0 = Republican governor and legislature; 1 = independent Governor and Republican legislature or Republican governor and split legislature; 2 = Democratic governor and Republican legislature or independent governor and split legislature or Republican governor and Democratic legislature; 3 = Democratic governor and split legislature or independent governor and Democratic legislature; and 4 = Democratic governor and Democratic legislature.

state has adopted policy requiring ID or photo ID, as well as the strictness of the policy (e.g.

whether citizens can submit a provisional ballot).[5] Fourth, to incorporate policy legacies, I

include a control to indicate whether *abortion was legal* (in either some or all circumstances) in a

state prior to the passage of Roe v. Wade in 1973. I also include the variable *South* indicating

whether a state is southern by U.S. Census definitions given the historical impact of southern

Democrats in steering welfare state legislation.

I then incorporate notions of the gendered and racialized welfare state into these

power/political variables with the disaggregation of specific factors by gender and race. This

includes *female poverty level*, an indicator which I *disaggregate by race*[6] and controls for the

percent of women, *White residents*, and *Black residents* within a state, as derived from Census

counts. I similarly *disaggregate voter turnout by gender and race*[7]. In subsequent models, I also

include the number of women in *need of publicly funded contraceptive services* as a percent of

the total number of women in need of contraceptives. These measures[8] are collected from

Guttmacher reports based on statistics of age, gender, and income from the U.S. Census Bureau

alongside data on sexual activity and fecundity from the National Survey of Family Growth

(NSFG). Need for publicly funded contraceptives is then converted into a proportion normalized

by overall need for contraceptives, also from the Guttmacher Institute. This measure notably

excludes need for other services that fall under the umbrella of family planning services, but it

still serves as a good proxy for the operationalization of this concept. This measure is also later

disaggregated by race (non-Hispanic White and non-Hispanic Black). Finally, given the role of

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[5] Specifically: 0 = none; 1 = non-strict non-photo; 2 = non-strict photo; 3 = strict non-photo; 4 = strict photo.
[6] The variables are constructed by subgroup, so that the denominator of the Black women in poverty variable is the total number of Black women for whom poverty level is determined, rather than the overall state population.
[7] Data for Black voting rates is unavailable for the following state-year combinations: ID, MT, SD, VT (2006); ID, MT, SD (2012). These states are excluded from analyses with this variable.
[8] For analysis of 2006 and 2010 data, this term is not lagged, due to data availability.

female legislatures in advocating for policies aimed at supporting women (Bolzendahl and Brooks 2007; Caiazza 2004; Cowell-Meyers and Langbein 2009), I add a variable for the *percent of the state legislature that is female*.

3.2 Methods

Analyses for this project are based on a series of OLS regressions, with standard errors clustered at the state level. The Guttmacher Institute offers this survey at multiple time points, but they caution comparison of changes from one time point to the next, given the limitations of the survey design and the difficulty of obtaining data on family planning services. Thus, even though we cannot necessary draw direct conclusions from a comparison of spending between years, we can observe a snapshot of the factors related to spending at these single points in time. I therefore proceed with OLS regression, rather than more sophisticated techniques such as panel regression or pooled cross-sectional time series. Previous use of OLS for similar analyses at single time points by other scholars (Moller 2002) supports this methodological choice.

The analyses themselves take on two forms. First, I evaluate spending variation normalized by state GDP. This is initially done through a series of OLS regressions using data that has been averaged across the three time points (2006, 2010, and 2015). Models are constructed to represent: 1) conventional welfare state variables; 2) the role of gender in power/political factors; and 3) the role of race in the same. I also combine factors from each of these models to create both "full" and "parsimonious" models.[9] Second, I evaluate the full and

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[9] Due to the limited sample size, combining all factors into a single regression tends to over-fit the data, and thus the parsimonious model is constructed through single elimination of those factors whose contribution to the overall sums of squares is limited.

parsimonious models using data at each individual time-point, in order to evaluate the robustness of my averaging.

The second phase of the analysis considers my alternate outcome, family planning spending normalized by total social spending. These again utilize data averaged across the time-points, and I repeat the first set of averaged regressions above. In comparing results from these two outcomes, I can provide additional robustness and nuance to evaluations of spending variation.

All analyses are conducted using Stata 13 (StataCorp 2013).

4 FINDINGS

4.1 Descriptive results

From reports (Hasstedt et al. 2017; Sonfield et al. 2008; Sonfield and Gold 2012), we recognize that Medicaid comprises the majority (74%) of funding sources for family planning spending by the state (Figure 3.1). Though state-only sources make up a relatively smaller slice,
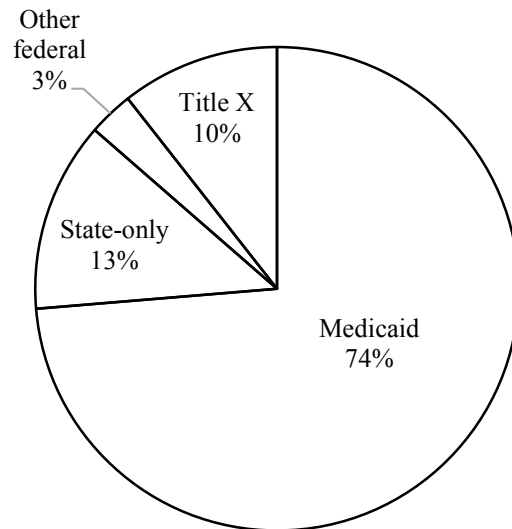
Figure 3.1 Sources of family planning funds, 3-year avg.

we are still able to observe meaningful variation by state in terms of overall family planning spending per GDP and per total social spending (Figure 3.2). Two observations are notable here. First, there are certain similarities between the two operationalizations of the outcome that stand out; for example, California, Mississippi, and Kentucky consistently spend generously in both. Texas, on the other hand, would appear to spend more generously when family planning spending is normalized by total social spending rather than state GDP. This suggests that while Texas' large GDP may not be being invested into family planning services specifically, when it is being invested into social services, a more generous amount of money is going toward family planning funds. Second, regardless of the outcome's operationalization, Kentucky serves as an extreme outlier among the states. This may in part be due to Kentucky's expanded Medicaid eligibility (Sommers et al. 2015), but further research should investigate in more nuance the processes involved here, particularly given the state's traditionally more conservative status.

The variation in family planning spending generosity can also be seen in Figure 3.3, in which states are ranked by the outcome, alongside overall need for publicly funded contraceptives. Here we again see Kentucky as an outlier, but necessarily so, given the high levels of need within the state. Yet several other states maintain similar levels of need without the proportionally high levels of funding. On the other hand, we also see states such as Washington, which falls on the higher end of spending generosity but boasts one of the lowest levels of need. In addition to this variation in spending, this figure also conveys the extent to which need as a whole is relatively high across all fifty states, with more than half of states boasting need for publicly funded contraceptives among more than 50% of their child-bearing populations.

per GDP

0.006%   0.044%

per total social spending

0.036%   0.295%
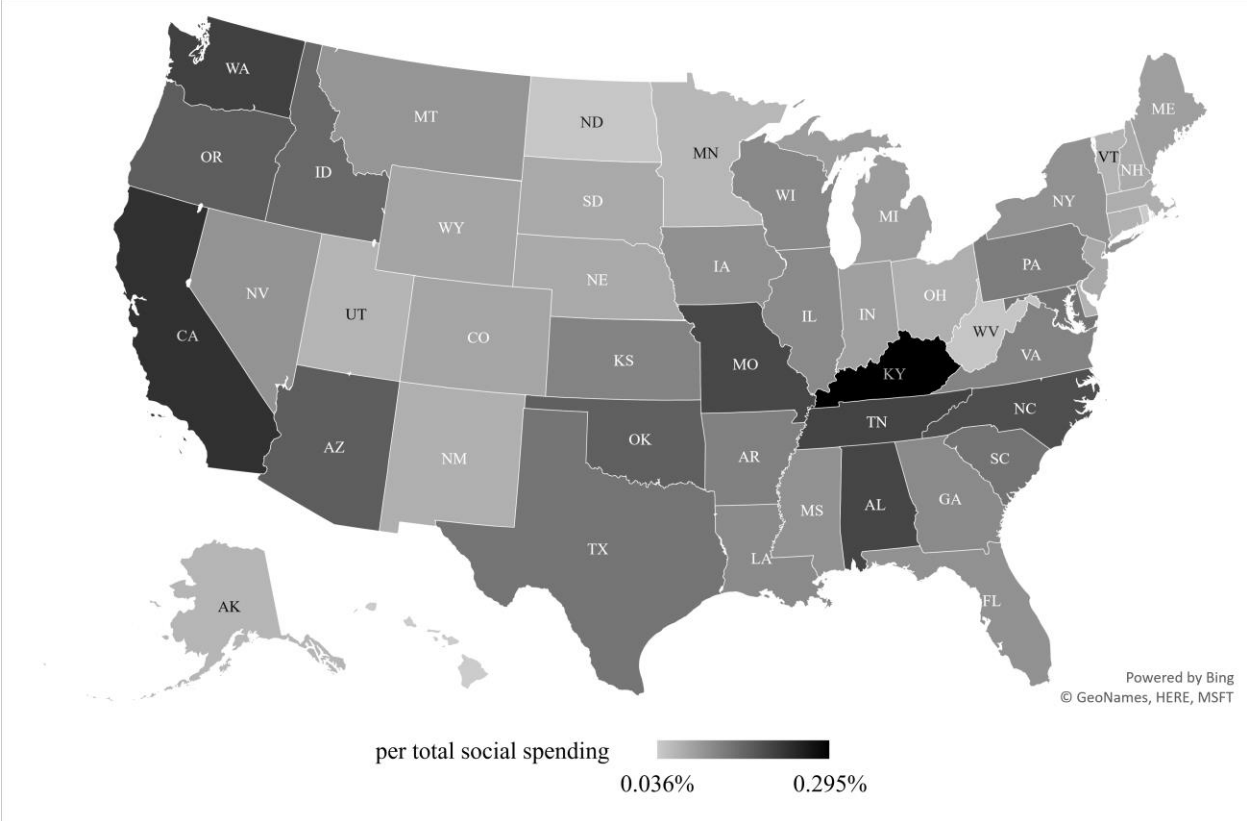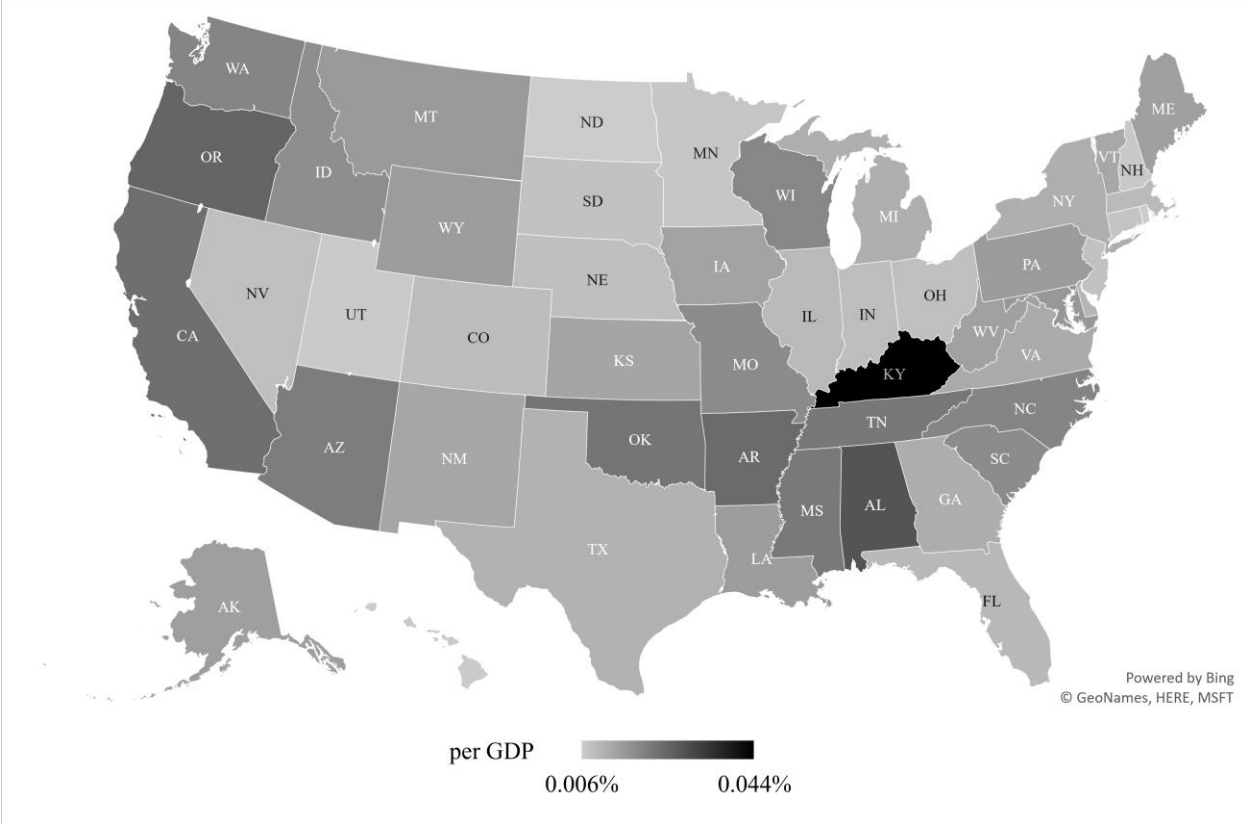
Figure 3.2 Family planning spending generosity by state
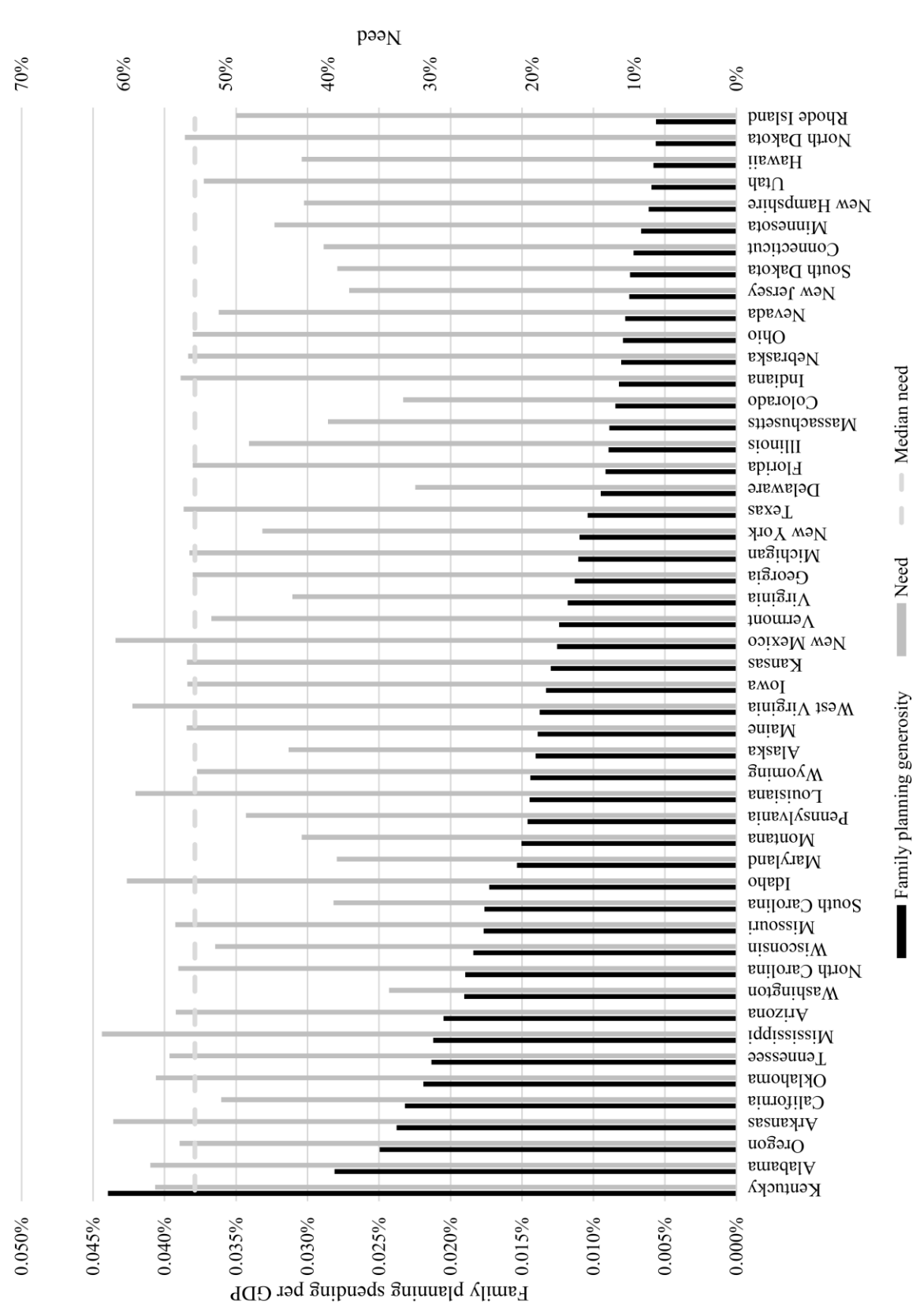
Figure 3.3 State rank of family spending per GDP and need, 3-year avg.

Next, considering the racialized history of social spending at large as well as policy around family planning services in particular, I break need down by race. The scatterplot in Figure 3.4 reflects this distinction. In addition to recognizing the disproportionately high need for
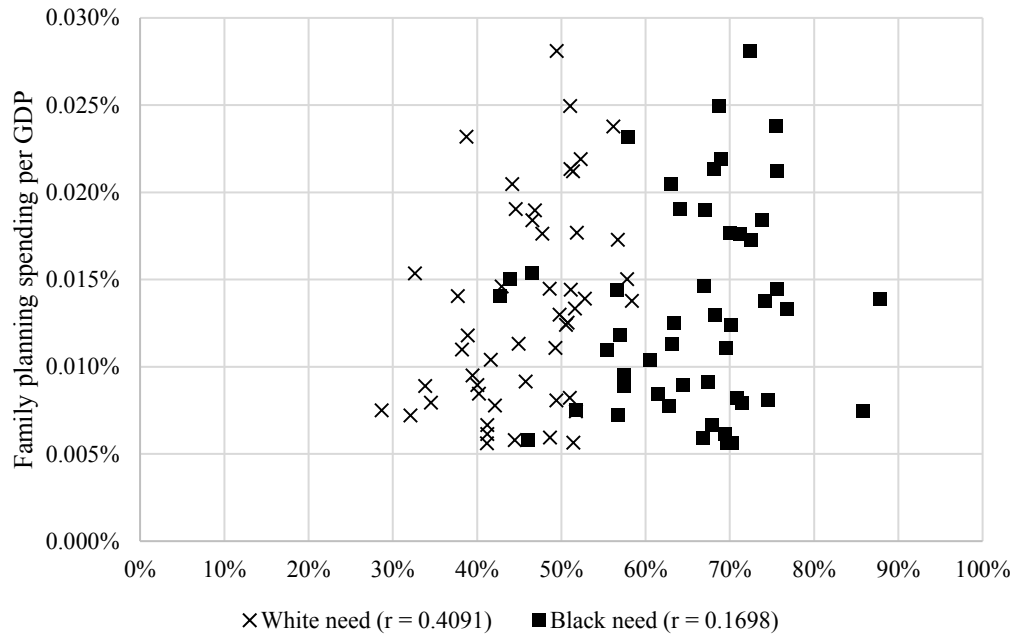
Figure 3.4 Scatterplot of need by race and family planning spending generosity

publicly funded contraceptives among Black women, we can also recognize the extent to which each correlates with our outcome. Notably, need for White women is significantly correlated with the outcome while need for Black women is not. When median-centered need is disaggregated by states among their ranking for family planning spending (Figure 3.5), Kentucky no longer appears an outlier, with relatively close values for both White and Black women, though both remain somewhat high. We can compare this to a state such as Ohio, where Black women's needs are distinctly higher than White women's, relative to other states, and yet funding generosity remains minimal. Thus, with a state such as Ohio we see suggestions of the role of racialized policy making as it responds to women's needs.
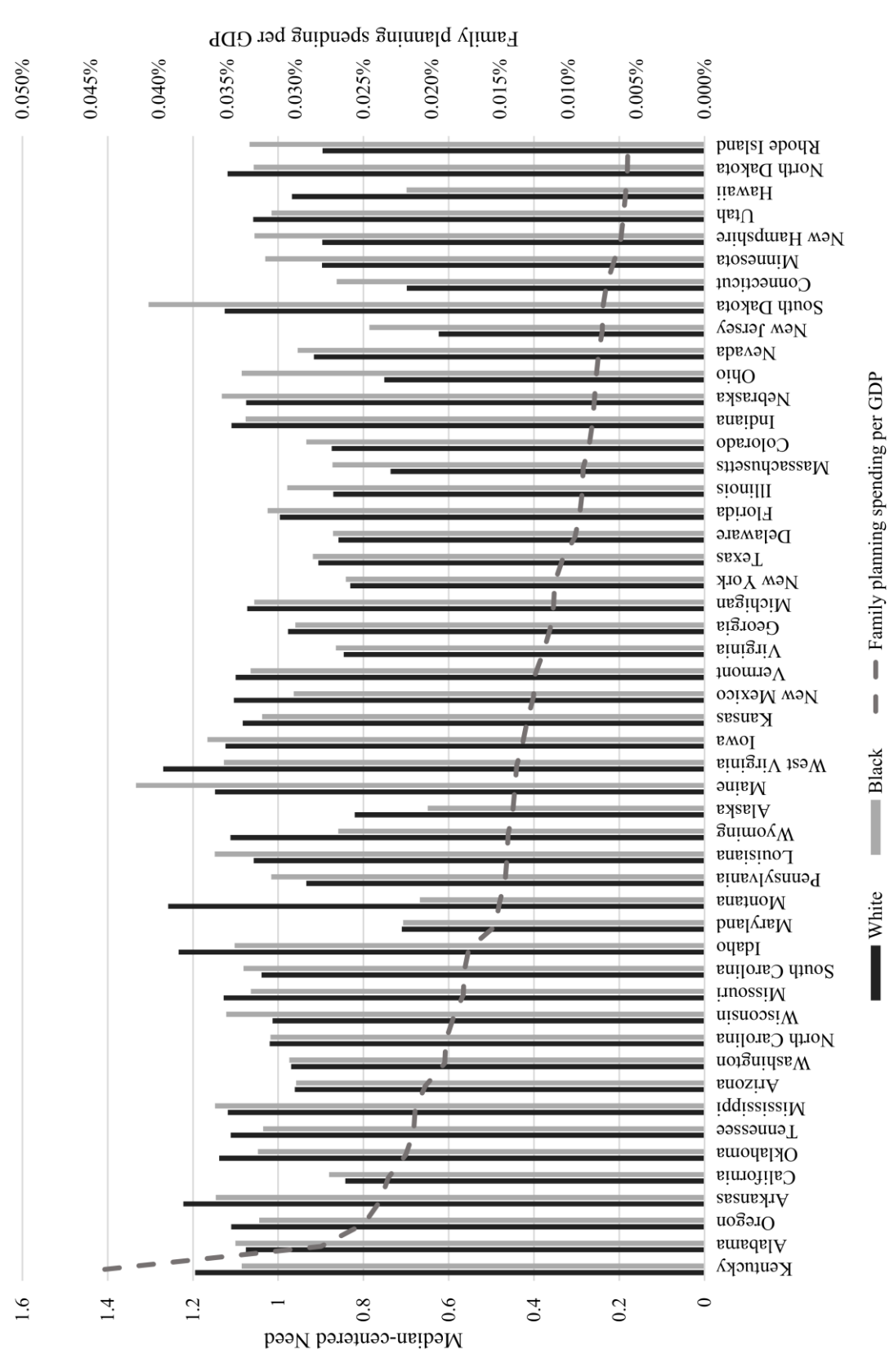
Figure 3.5 State median-centered need by race ranked by family planning spending per GDP

Finally, though hesitations should be made before comparing variation between the three time points (see above), Figure 3.6 displays family planning spending per GDP and per total social spending, with separate *y*-axes, for 2006, 2010, 2015. Here we see a slight drop in 2015, though all measures fall within one standard deviation of each other.
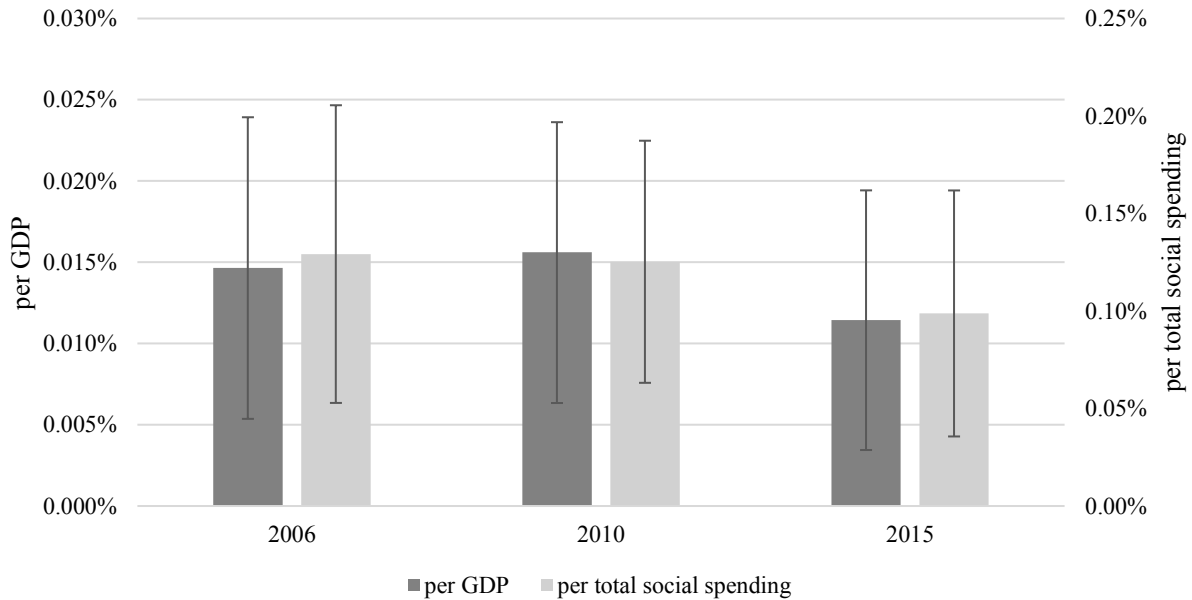
Figure 3.6 Comparison of average spending generosity averaged over time

4.2 Regression results: Averaged Spending per GDP

Moving on to inferential findings, for the first set of regressions, I consider variation in spending for *family planning services per state GDP* averaged across the three time points. Results can be seen in Tables 3.2-5. When looking at the conventional measures of welfare state development (Table 3.2), we see that *poverty rate* is positively, significantly associated with spending generosity, suggesting the utility of the functionalist perspective. This significant, positive association persists even once power/political factors are added (Model 3). Among power/political factors, none are significant on their own nor when added to functional factors.

111

The parsimonious model (4), however, shows that states with stricter *voter ID laws* tend to have less generous family planning spending. Regardless, the higher r^2 for the functional factors (0.346) over the power/political factors (0.183) reinforces the suggested role of functional variables in shaping spending outcomes.

Moving on to Table 3.3, I incorporate gendered perspectives of the welfare state into the power/political variables. First, disaggregating *poverty by gender* shows that both male (Model 2a) and female (Model 2b) poverty levels are associated with greater spending generosity.[10] Though we would expect that female poverty level might be more important in driving spending generosity than male poverty, given the targeting of family planning services at women, this is not the case; indeed, the standardized coefficient for male poverty level is slightly higher (though not necessarily significantly so). Second, I account for the relationship between *need for publicly-funded contraceptives* and spending generosity in Model 3. Similar to Model 2b, need is positively, significantly associated with spending generosity. *Percent female*, however, is not significantly associated, nor is *voter turnout by gender*. This second finding is not particularly surprising, given that overall voter turnout was not significant (Model 1). For my final gendered variable, I include *female legislative representation*. This is significant and positively associated, though marginally so. Pairing down Model 3 to the more parsimonious model (7) reveals the positive, significant association between having a more *democratic legislature* and being a *Southern state* with spending generosity, as well as the persistent effect of *need* on spending generosity.

Next, I incorporate racialized welfare state terms into the power/political model (Table 3.4). Here we see that when both *female poverty* (Model 2) and *need* (Model 3) are

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[10] Male and female poverty are included in separate regressions due to collinearity ($r = 0.9835$).

disaggregated by race, only the White terms for both factors are significantly associated with the outcome. This suggests that states with higher proportions of White women in poverty, or more specifically in in need of these services, have more generous funding for such. Conversely, states are not equally responsive to levels of Black female poverty and need. Although disaggregating *population by race* (Model 4) shows no significant difference between Black and White population proportions, we see a marginally negative effect of *White voter turnout* (Model 5) on spending generosity. This effect disappears, however, in the parsimonious model (6) that contains both *need* and *voter turnout disaggregated by race*. Here, *White women's needs* as well as having *liberal pre-Roe abortion policy* are positively, significantly associated with the outcome.

Finally, Table 3.5 shows the full (Models 1b and 2b) and parsimonious (Models 1c and 2c) models that incorporate these gendered and racialized factors alongside conventional measures of welfare state development. In particular, I highlight the persistent difference between White and Black women's needs and spending generosity. In Models 1a and 2a we see that White women's poverty and need are both positively associated with our outcome, while those for Black women remain insignificant. This relationship persists in both the full and parsimonious models; indeed, in Model 2c we see a marginally negative association between Black female need and the outcome, reinforcing this distinction between White and Black women's needs in shaping policy for family planning spending.

Of the more conventional welfare state measures in these final tables, only one is significantly associated with the outcome in the full models (*unemployment*, positively so), likely due to these models being over-fitted. In the parsimonious model with *need* (Model 2c), however, we see that unemployment remains positively associated with spending generosity,

reflecting that states with higher levels of unemployment spend more generously on family planning services. Of marginal significance is the *South* term (positive), reflecting the findings in Model 7 of Table 3.3.

4.3 Regression Results: Annual Spending per GDP

In order to corroborate these findings, we next consider the full model at each of the three individual time points whose data were averaged for the previous set of analyses. Additionally, we can highlight potential shifts in findings over time. Beginning with data from 2006 (Table 3.6), we see results that strongly reflect those from the averaged models. Both *White female poverty* and *need* are significantly positively associated with spending generosity throughout the models, with *Black need* negatively associated with such in the final Model (2c). Interestingly, we see more significance in conventional welfare state variables in the full model evaluating *need by race* (Model 2b) than in the previous regressions, including a positive association between Gini coefficient and spending generosity and a marginally positive association between voter turnout and spending. The significant associations between *unemployment* (positive) and *voter ID laws* (negative) persist in the parsimonious model (2c).

In 2010 (Table 3.7), we again see similar results, particularly for the significant, positive association between *White female poverty* and *need* and my outcome. Here we also see a negative association between *GDP per capita* and spending generosity in one of the full models (2b), as well as the persistent relationship between *unemployment* and generosity (Models 1c, 2b, and 2c). In comparing r^2 values, those for regressions based on the 2010 data are markedly larger for almost every model, suggesting that these particular variables do a better job of describing

variation in spending generosity in 2010 than in 2006. While this is notable, further research

would need to be conducted in order to determine the precise reasons for this shift.

Finally, data from 2015 (Table 3.8) reflect a somewhat similar pattern of correlates as the

other two years, yet results appear to be somewhat tempered. *White female poverty* is only

marginally associated with spending generosity in the first two models, and indeed becomes

insignificant in explaining such in the parsimonious model. Similarly, *White need* is significant

in Models 2a and 3c. Importantly, although it loses its significance in the full model (2b), here

we see a negative association between *Black need* and spending, perhaps reflecting similar

processes. This negative relationship persists, though diminishes, in the parsimonious model.

Furthermore, the r^2 values for these models are lower than either of the other two, once again

suggesting a limitation to the extent to which these variables successfully explain variation in our

outcome.

4.4 Regression Results: Family Planning Spending per Total Social Spending

Turning to my second, outcome, Tables 3.9-12 show results for variables regressed on

family planning spending as a percent of total social spending for the state.[11] With these tests, I

am able to evaluate the robustness of the findings from the averaged spending per GDP models,

as well as consider the extent to which results might differ based on my operationalization of

spending "generosity." Overall, results do differ somewhat from those in Tables 3.2-5.

In Table 3.9 we see the conventional welfare state measures regressed on my second

outcome. Similar to the first set of models, the functional factors seem to play a larger role in

shaping spending generosity than do the conventional power and political factors. This is

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[11] Data averaged across the three time points.

highlighted by the lack of significance among this second set of factors, as well as the difference in r^2 between the two models (1 and 2). When combined (Model 3), only the *Gini coefficient* is significantly, positively associated, and only marginally so. In the parsimonious model (Model 4), however, we see that *GDP per capita* is negatively associated with spending generosity, as is having an *older* population. Where the direction of the Gini coefficient might suggest the active response of state policy to alleviating inequality within the state, the negative association between GDP per capita and spending generosity suggests the opposite, that wealthier states invest less readily in family planning spending. The negative association between older populations and spending generosity may be related to the extent to which family planning policy is targeted at women of child-bearing age. Importantly, poverty, which was so persistently significant in those models of spending per GDP, fails to reach significance in all of these tests.

Next, Table 3.10 incorporates gendered aspects of the welfare state into the power/political factors. Not unexpectedly, given the results from the previous table, few of these factors are found to be significant. Indeed, the only gendered term that is, *female poverty*, is only marginally significant, as is the *male poverty* measure. In creating a parsimonious model (Model 7), we are able to see positive significant association between the outcome and the coefficient for *need* ($p<0.1$); additionally *South* and *pre-Roe abortion legislation* remain in the model, though neither are significant.

Moving on to Table 3.11, we have measures related to the racialized welfare state. Similar to the previous set of models, nothing is significant here. Most notably, disaggregating *poverty* and *need* by race does not yield significance for either factor, in opposition to the findings when spending is normalized by GDP. Nevertheless, I combine gendered and racialized factors to create full models in Table 3.12. Here the persistent positive significance of the *Gini*

coefficient in predicting spending variation remains evident in both full and parsimonious models. Given the lack of significance of the *racialized poverty* and *need* measures in the previous set of models, it is not surprising to see inconsistent significance here. Nevertheless, effects, when marginally significant in the parsimonious models (1c and 2c) are in the expected direction, with *White female poverty/need* positively associated with the outcome.

5 DISCUSSION AND CONCLUSION

This chapter seeks to narrow the scope from the previous one, in that here we focus on public spending solely for family planning services. In doing so, I am able to evaluate the extent to which conventional measures of welfare state development apply to this narrower, particularly gendered, form of social support. In addition, I consider how the racialized nature of reproductive healthcare policy, both historically and currently, may shape recent funding decisions.

The findings above offer several implications for understanding observed variation in spending for reproductive healthcare in the U.S. First, descriptively, we see that the majority of public spending comes from Medicaid funds. In an era where questions of the continued need for Medicaid arise in the public and political spheres, this data from the Guttmacher Institute highlights the ongoing need for these funds, particularly for women. Additionally, we are able to identify specific states that either exemplify or counter our expectations around the relationships between social spending and need. Where a state such as Kentucky touts the most generous amounts of funding alongside relatively high levels of need, North Dakota represents the opposite. More detailed case analysis, particularly for Kentucky, whose spending generosity towers over that of its peers, would be helpful in further understanding these differences.

Importantly, these descriptive statistics also highlight the real need for publicly-funded contraceptives among the population, and particularly for Black women.

Second, we are able to further evaluate the hypotheses posited in Chapter 1. In consideration of the role of functional factors in shaping spending generosity for family planning services, we see relatively strong support. This comes in the form of the positive association between poverty level, alongside unemployment, and family planning spending (per GDP) as well as between having high income inequality and spending (per total social spending). In evaluation of the conventional measures of power resource and political institutionalism, we find limited support for factors such as party identification, level of unionization, or pre-Roe abortion law.

Nevertheless, disaggregating poverty and need by race yields fruitful results when considering the extent to which class power in shaping policy decisions is tempered by the race of those in need. In particular, I note the extent to which White female poverty and need are positively associated with our outcome (spending per GDP), while Black female poverty and need either show no significant association or are negatively associated with such. This finding is illustrated in Figure 3.7.

Given the history of racially discriminatory patters of social spending in the U.S. (Gordon 1994; Quadagno 2004; Schram et al. 2003), these findings offer empirical support of this problematic legacy. In addition, they offer support for the hypothesis which describes the role of the state in perpetuating inequality rather than alleviating it (Delgado and Stefancic 2012; Meyer 1994). Still, where other research emphasizes the coercive use of family planning policy that disproportionately targets women of color (Correa and Reichmann 1994; Farrell et al. 1983; Greil et al. 2011; Gurr 2011; King and Meyer 1997), these findings suggest that Black women's

access to these services remains a tangible barrier. Future research would do well to better

disentangle this tension.
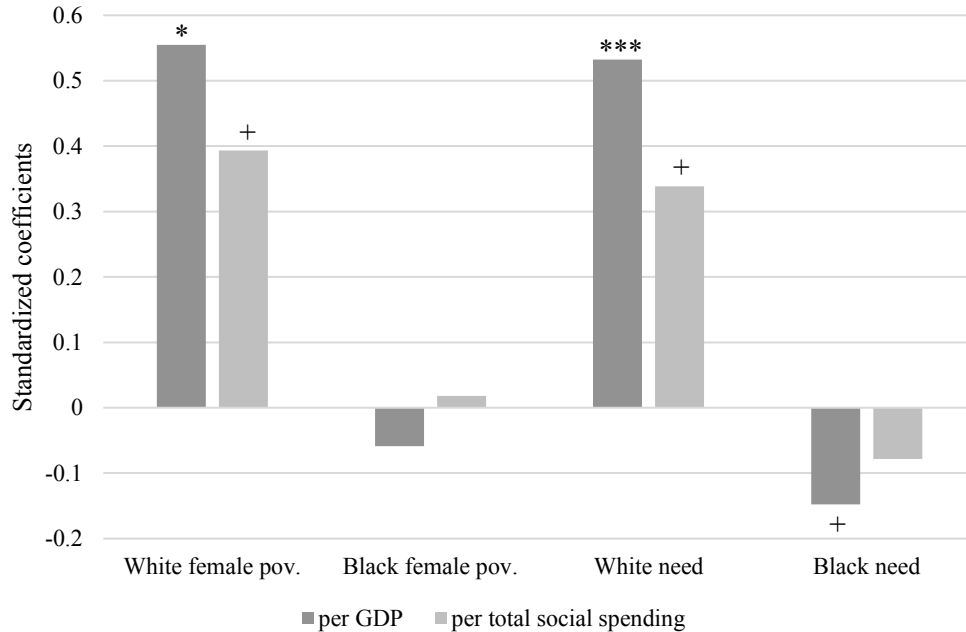
Figure 3.7 Standardized coefficients for female poverty and need disaggregated by race regressed on spending per
GDP (parsimonious model)

Finally, in consideration of the gendered nature of the outcome, I predicted that state

spending would be reflective of the needs of women over men, as well as the role of female

legislatures in shaping such policies. Findings here are mixed. Female poverty and need are

significantly, positively associated with the primary outcome, but so are male poverty levels.

Additionally, female poverty and need seem to have little to no effect when spending is

normalized by total social spending. In consideration of the gender makeup of the state

legislature, female legislative representation is only marginally significant in one model, and

indeed we see a negative association with our outcome. This finding would appear to counter the

hypothesis that female legislative representation matters in passing more robust "female-

friendly" welfare policy (Bolzendahl and Brooks 2007; Paxton et al. 2008; Poggione 2004). It

would be worth further investigation to see the extent to which this holds for other forms of reproductive policy, rather than social spending, given that female legislatures themselves likely have access to more robust employment-based insurance coverage for such services. Nevertheless, overall, these findings support the incorporation of gendered and racialized measures when investigating welfare state spending at large, and reproductive healthcare spending in particular.

Additionally, this chapter makes use of two different outcomes in evaluating correlates for family planning spending generosity. When regressing on spending per GDP, we see the extent to which racialized factors seem to play a larger role in shaping spending decisions, yet this finding does not hold up when normalizing by total social spending. This suggests that among states that are investing their overall social spending in family planning services, there appears to be less of a bias toward White women's needs over Black women's. The same cannot be said for states that are investing large proportions of their overall wealth into these same services. Further research might consider additional operationalizations of the outcome, such as spending per number of women in need.

This project offers novel analysis on a rich dataset, but some limitations and further directions are worth noting. First, this chapter only examines specific family planning services, namely contraception and sterilization. This notably excludes funding for abortions. Given the history and politicization of abortion in the U.S., further investigation of factors related to spending for abortion, and comparison with spending for other reproductive healthcare services, would be a logical next step. I pursue this question further in Chapter 4.

Second, this project only considers funding from three time points. Although data availability is limited, there are relatively comparable measures for four other points in time

going back to 1980. Examination of what drives changes in funding for a specific state over time might help to reveal the extent to which policy legacies continue to play a part in current funding decisions. Additionally, delving further into the difference in r^2 values between each of the years' data, one suggested factor to consider would be the implementation of the Affordable Care Act (ACA) between 2010 and 2014. Under the ACA, not only have states had the opportunity to expand their Medicaid coverage, but stipulations now demand insurance companies to provide birth control coverage at no cost to the patient. This could temper the variation in spending outcomes by state such that these more conventional models fail to satisfactorily explain the variation that remains. As this aspect of the ACA remains highly contested (National Women's Law Center 2017), future research would do well to continue evaluating the extent to which this aspect of the ACA may alleviate some of the inequality present in current state family planning funding policies.

Third, though regression techniques are the most commonly employed in this type of analysis, a parallel analysis using alternative methods such as QCA, or a more detailed case study of specific states, would allow us to examine more closely how these factors interplay with each other. In particular, it could be illuminating to consider which states expanded or failed to expand their Medicaid coverage under the ACA, and how this may have shifted coverage for family planning services.

These limitations aside, this project offers two main contributions to the sociological literature. First, in its examination of spending for reproductive services, it offers a more gender- and race-sensitive approach to the welfare state development literature. Second, it offers an empirical approach to our well-developed understanding of the ways in which reproductive policy has historically and currently been used to discriminate against women at large, and

women of color or those experiencing poverty, in particular. Availability of family planning

services is crucial for women's wellbeing, and yet the extent to which they are funded and

accessible by those most in need critically varies extensively across the U.S. By expanding on

our collective understanding of the ways in which the full participation of women in society may

be impeded by certain policies, this project takes a small step toward alleviating unnecessary

injustice.

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Table 3.1 Descriptive statistics, 3-year avg. (N = 150)

Type	Variable	Mean	St. Dev.	Min.	Max
Outcome	Family planning spending per GDP	0.014	0.007	0.006	0.044
	Family planning spending per total social spending	0.118	0.056	0.036	0.295
Functional	GDP per capita	0.05	0.01	0.04	0.08
	Gini coefficient	0.45	0.02	0.42	0.50
	Unemployment rate	6.98	1.42	3.3	10.3
	% under 18	23.90	1.81	20.75	31.12
	% 65 and older	13.34	1.67	7.60	17.43
	Poverty status	13.68	3.02	8.23	21.61
Power/Political	Unionization	10.78	5.25	3.17	24.43
	Voter turnout	63.98	5.02	51.4	75.8
	Democratic gov't	1.85	1.15	0	3.67
	Voter ID laws	0.97	0.99	0	3.67
	South	0.32	0.47	0	1
	Pre-Roe abortion law	0.40	0.49	0	1
Gender	Poverty by gender				
	Male	12.31	2.75	7.37	19.21
	Female	15.00	3.29	9.08	23.83
	Need	49.84	7.78	31.45	62.14
	% Female	50.65	0.74	48.08	51.70
	Voter turnout by gender				
	Male	60.63	5.75	47.4	71.5
	Female	65.93	5.13	53.63	78.37
	% Female legislature	23.81	6.72	10.97	37.33
Race	Female poverty by race				
	White female	11.19	2.60	6.15	18.58
	Black female	28.74	6.88	10.26	49.32
	Need by race				
	White female	45.95	7.09	28.65	58.35
	Black female	65.81	9.54	42.72	87.76
	% White	72.00	15.36	23.48	94.65
	% Black	10.25	9.57	0.55	37.24
	Voter turnout by race				
	White	66.27	4.62	53.1	77.13
	Black[+]	61.69	11.77	36.1	100

✛ N = 47; See text for details.

Table 3.2 OLS regression of traditional variables on family planning spending per GDP (3-year avg.; N=50)

	Model 1		Model 2		Model 3		Model 4	
	beta	se	beta	se	beta	se	beta	se
GDP per capita	-0.12	(0.15)			-0.19	(0.19)		
Gini coefficient	-0.12	(0.13)			-0.10	(0.15)		
Unemployment rate	0.04	(0.14)			0.02	(0.14)		
% under 18	-0.33	(0.20)			-0.15	(0.22)		
% 65 and older	-0.29	(0.22)			-0.23	(0.24)		
Poverty rate	0.60 **	(0.22)			0.53 *	(0.24)	0.54 ***	(0.14)
Unionization			-0.19	(0.12)	0.05	(0.17)		
Voter turnout			-0.12	(0.11)	0.02	(0.12)		
Democratic gov't			0.14	(0.18)	0.07	(0.15)		
Voter ID laws			-0.10	(0.12)	-0.18	(0.13)	-0.23 *	(0.11)
South			0.29	(0.20)	0.20	(0.18)	0.21	(0.14)
Pre-Roe abortion law			0.08	(0.16)	0.06	(0.16)		
r^2	0.343		0.183		0.422		0.378	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.3 OLS regression of gender variables on family planning spending per GDP (3-year avg.; N=50)

	Model 1		Model 2a		Model 2b		Model 3		Model 4	
	beta	se	beta	se	beta	se	beta	se	beta	se
Unionization	-0.19	(0.12)	0.03	(0.15)	0.04	(0.15)	-0.03	(0.14)	-0.19	(0.12)
Voter turnout	-0.12	(0.11)	0.04	(0.10)	0.03	(0.10)	0.01	(0.10)	-0.12	(0.11)
Democratic gov't	0.14	(0.18)	0.05	(0.15)	0.05	(0.15)	0.19	(0.17)	0.16	(0.20)
Voter ID laws	-0.10	(0.12)	-0.18	(0.11)	-0.18	(0.12)	-0.04	(0.12)	-0.09	(0.13)
South	0.29	(0.20)	0.21	(0.18)	0.19	(0.17)	0.27	(0.19)	0.30	(0.20)
Pre-Roe abortion law	0.08	(0.16)	0.05	(0.15)	0.06	(0.15)	0.18	(0.15)	0.08	(0.16)
Poverty by gender										
Male			0.56 **	(0.16)						
Female					0.55 **	(0.17)				
Need										
% Female							0.46 **	(0.13)		
Voter turnout by gender										
Male										
Female										
% Female legislature									-0.05	(0.12)
r^2	0.177		0.391		0.377		0.308		0.179	

Robust standard errors in parentheses

*** $p<0.001$, ** $p<0.01$, * $p<0.05$, + $p<0.10$

Table 3.3 *Continued*

	Model 5a		Model 5b		Model 6		Model 7	
	beta	se	beta	se	beta	se	beta	se
Unionization	-0.21 +	(0.12)	-0.18	(0.12)	-0.13	(0.13)		
Voter turnout					-0.07	(0.11)		
Democratic gov't	0.17	(0.19)	0.13	(0.18)	0.28	(0.19)	0.31 +	(0.16)
Voter ID laws	-0.09	(0.12)	-0.10	(0.12)	-0.06	(0.14)		
South	0.27	(0.19)	0.29	(0.20)	0.22	(0.17)	0.27 *	(0.13)
Pre-Roe abortion law	0.10	(0.15)	0.09	(0.16)	0.11	(0.15)		
Poverty by gender								
Male								
Female								
Need							0.36 **	(0.13)
% Female								
Voter turnout by gender								
Male	-0.19	(0.13)						
Female			-0.11	(0.10)				
% Female legislature					-0.34 +	(0.19)	-0.23	(0.18)
r^2	0.2		0.18		0.274		0.35	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

132

Table 3.4 OLS regression of race variables on family planning spending per GDP (3-year avg.; N=50)

	Model 1		Model 2		Model 3		Model 4		Model 5+		Model 6+	
	beta	se	beta	se	beta	se	beta	se	beta	se	beta	se
Unionization	-0.19	(0.12)	0.04	(0.14)	0.01	(0.14)	-0.15	(0.12)	-0.18	(0.12)		
Voter turnout	-0.12	(0.11)	0.20	(0.20)	-0.04	(0.12)	-0.22 +	(0.13)				
Democratic gov't	0.14	(0.18)	-0.09	(0.16)	0.10	(0.17)	0.14	(0.18)	0.18	(0.18)	0.21	(0.15)
Voter ID laws	-0.10	(0.12)	-0.20	(0.15)	-0.07	(0.14)	-0.09	(0.14)	-0.09	(0.13)		
South	0.29	(0.20)	0.20	(0.15)	0.27	(0.19)	0.24	(0.21)	0.22	(0.20)		
Pre-Roe abortion law	0.08	(0.16)	0.18	(0.14)	0.17	(0.15)	0.18	(0.15)	0.13	(0.16)	0.28 *	(0.12)
Female poverty by race												
White female			0.74 *	(0.33)								
Black female			-0.16	(0.24)								
Need by race												
White female					0.45 **	(0.15)					0.42 **	(0.14)
Black female					-0.04	(0.13)					0.04	(0.13)
% White							0.24	(0.18)				
% Black							0.10	(0.16)				
Voter turnout by race												
White									-0.23 +	(0.12)	-0.20	(0.15)
Black									0.06	(0.11)	0.09	(0.12)
r^2	0.177		0.433		0.297		0.19		0.192		0.192	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

+ N = 47; See text for details.

133

Table 3.5 OLS regression of all variables on family planning spending per GDP (3-year avg.; N=50)

	Model 1a beta	Model 1a se	Model 1b beta	Model 1b se	Model 1c beta	Model 1c se
Female poverty by race						
White female	0.60 *	(0.24)	0.93 *	(0.37)	0.55 *	(0.24)
Black female	-0.05	(0.17)	-0.30	(0.23)	-0.06	(0.14)
Need by race						
White			0.15	(0.13)	0.25 **	(0.09)
Black			-0.25	(0.16)	-0.22	(0.13)
Unemployment			0.18	(0.14)	0.20	(0.12)
Voter ID laws			0.05	(0.18)		
South			0.16	(0.14)		
GDP per capita			0.13	(0.20)		
Gini			-0.14	(0.19)		
% under 18			0.03	(0.16)		
% 65 and older			0.38	(0.23)		
Unionization			-0.06	(0.16)		
Voter turnout			0.04	(0.15)		
Democratic gov't						
Pre-Roe abortion law						
r^2	0.334		0.557		0.47	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.5 *Continued*

	Model 2a		Model 2b		Model 2c	
	beta	se	beta	se	beta	se
Female poverty by race						
White female						
Black female						
Need by race						
White	0.45 **	(0.15)	0.56 **	(0.21)	0.53 ***	(0.13)
Black	-0.08	(0.13)	-0.21	(0.18)	-0.15 +	(0.09)
Unemployment			0.32 *	(0.13)	0.40 ***	(0.11)
Voter ID laws			-0.17	(0.13)	-0.19	(0.12)
South			0.21	(0.17)	-0.19	(0.12)
GDP per capita			-0.06	(0.16)	0.26 +	(0.13)
Gini			0.16	(0.12)		
% under 18						
% 65 and older						
Unionization			-0.05	(0.15)		
Voter turnout			0.09	(0.13)		
Democratic gov't			0.04	(0.15)		
Pre-Roe abortion law			0.04	(0.16)		
r^2	0.171		0.457		0.429	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.6 OLS regression of all variables on family planning spending per GDP (2006; N=50)

	Model 1a beta	Model 1a se	Model 1b beta	Model 1b se	Model 1c beta	Model 1c se	Model 2a beta	Model 2a se	Model 2b beta	Model 2b se	Model 2c beta	Model 2c se
Female poverty by race												
White female	0.42 *	(0.18)	0.72 +	(0.37)	0.42 *	(0.18)						
Black female	0.11	(0.15)	-0.25	(0.24)	0.01	(0.12)						
Need by race												
White							0.44 *	(0.17)	0.69 **	(0.25)	0.55 **	(0.17)
Black							-0.11	(0.15)	-0.42 +	(0.23)	-0.26 +	(0.14)
Unemployment			0.23	(0.23)	0.19 +	(0.11)			0.22 +	(0.12)	0.33 *	(0.13)
Voter ID laws			-0.26	(0.17)	-0.29 *	(0.11)			-0.25 *	(0.12)	-0.31 **	(0.11)
South			0.10	(0.17)	0.12	(0.12)			0.23	(0.18)	0.22	(0.13)
GDP per capita			0.12	(0.30)					-0.09	(0.19)		
Gini			0.12	(0.25)					0.33 *	(0.16)		
% under 18			-0.16	(0.18)								
% 65 and older			-0.15	(0.26)								
Unionization			-0.11	(0.21)					0.04	(0.14)		
Voter turnout			0.42	(0.26)					0.34 +	(0.17)		
Democratic gov't			-0.02	(0.19)					0.06	(0.15)		
Pre-Roe abortion law			0.06	(0.17)					0.04	(0.15)		
r^2	0.224		0.426		0.332		0.152		0.471		0.371	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

136

Table 3.7 OLS regression of all variables on family planning spending per GDP (2010; N=50)

	Model 1a		Model 1b		Model 1c	
	beta	se	beta	se	beta	se
Female poverty by race						
White female	0.63 ***	(0.18)	0.53 *	(0.24)	0.51 **	(0.15)
Black female	-0.11	(0.12)	-0.12	(0.22)	-0.09	(0.10)
Need by race						
White						
Black						
Unemployment			0.17	(0.12)	0.32 **	(0.10)
Voter ID laws			-0.14	(0.15)	-0.15	(0.14)
South			0.25 *	(0.12)	0.30 **	(0.11)
GDP per capita			-0.17	(0.13)		
Gini			0.10	(0.13)		
% under 18			0.14	(0.20)		
% 65 and older			-0.06	(0.17)		
Unionization			0.04	(0.15)		
Voter turnout			0.08	(0.19)		
Democratic gov't			0.03	(0.13)		
Pre-Roe abortion law			0.19	(0.13)		
r^2	0.332		0.600		0.543	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.7 *Continued*

	Model 2a		Model 2b		Model 2c	
	beta	se	beta	se	beta	se
Female poverty by race						
White female	0.37 **	(0.13)				
Black female	0.01	(0.11)				
Need by race						
White			0.27 *	(0.11)	0.39 **	(0.12)
Black			-0.12	(0.12)	-0.07	(0.07)
Unemployment			0.28 *	(0.13)	0.42 **	(0.12)
Voter ID laws			-0.06	(0.15)	-0.08	(0.14)
South			0.28 *	(0.13)	0.35 **	(0.12)
GDP per capita			-0.28 *	(0.12)		
Gini			0.07	(0.11)		
% under 18						
% 65 and older						
Unionization			-0.04	(0.13)		
Voter turnout			-0.07	(0.11)		
Democratic gov't			0.11	(0.15)		
Pre-Roe abortion law			0.14	(0.14)		
r^2	0.14		0.558		0.476	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.8 OLS regression of all variables on family planning spending per GDP (2015; N=50)

	Model 1a		Model 1b		Model 1c		Model 2a		Model 2b		Model 2c	
	beta	se	beta	se	beta	se	beta	se	beta	se	beta	se
Female poverty by race												
White female	0.47 +	(0.25)	0.66 +	(0.34)	0.36	(0.27)						
Black female	-0.08	(0.15)	-0.25	(0.18)	-0.03	(0.16)						
Need by race												
White							0.40 *	(0.15)	0.40	(0.25)	0.41 **	(0.15)
Black							-0.19	(0.12)	-0.29 *	(0.12)	-0.20 +	(0.11)
Unemployment			-0.004	(0.18)	0.17	(0.11)			0.20	(0.19)	0.27 *	(0.11)
Voter ID laws			0.01	(0.13)	0.08	(0.13)			0.08	(0.12)	0.08	(0.12)
South			0.16	(0.16)	0.08	(0.15)			0.18	(0.18)	0.14	(0.16)
GDP per capita			-0.10	(0.20)					-0.10	(0.20)		
Gini			0.11	(0.15)					0.04	(0.13)		
% under 18			0.14	(0.25)								
% 65 and older			-0.28	(0.26)								
Unionization			0.30	(0.22)					0.14	(0.20)		
Voter turnout			0.40 *	(0.17)					0.18	(0.12)		
Democratic gov't			-0.14	(0.21)					-0.14	(0.26)		
Pre-Roe abortion law			-0.08	(0.19)					-0.05	(0.19)		
r^2	0.184		0.393		0.228		0.109		0.262		0.228	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.9 OLS regression of traditional variables on family planning spending per total social spending (3-year avg.; N=50)

	Model 1		Model 2		Model 3		Model 4	
	beta	se	beta	se	beta	se	beta	se
GDP per capita	-0.30 +	(0.15)			-0.30	(0.18)	-0.32 *	(0.12)
Gini coefficient	0.27 +	(0.14)			0.28 +	(0.15)	0.31 **	(0.11)
Unemployment rate	0.05	(0.13)			0.09	(0.13)		
% under 18	-0.06	(0.22)			0.06	(0.27)		
% 65 and older	-0.28	(0.20)			-0.23	(0.23)	-0.27 *	(0.13)
Poverty rate	0.10	(0.24)			0.00	(0.26)		
Unionization			-0.19	(0.15)	-0.06	(0.19)		
Voter turnout			-0.11	(0.15)	0.02	(0.17)		
Democratic gov't			0.07	(0.18)	0.08	(0.16)		
Voter ID laws			-0.03	(0.14)	-0.10	(0.14)		
South			0.22	(0.19)	0.18	(0.20)	0.19	(0.15)
Pre-Roe abortion law			0.09	(0.16)	0.00	(0.16)		
r^2	0.252		0.128		0.301		0.28	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.10 OLS regression of gender variables on family planning spending per total social spending (3-year avg.; N=50)

	Model 1		Model 2a		Model 2b		Model 3		Model 4	
	beta	se	beta	se	beta	se	beta	se	beta	se
Unionization	-0.19	(0.15)	-0.04	(0.15)	-0.05	(0.15)	-0.11	(0.15)	-0.18	(0.14)
Voter turnout	-0.11	(0.15)	0.01	(0.16)	-0.01	(0.16)	-0.04	(0.16)	-0.11	(0.15)
Democratic gov't	0.07	(0.18)	0.01	(0.17)	0.01	(0.18)	0.09	(0.18)	0.05	(0.20)
Voter ID laws	-0.03	(0.14)	-0.09	(0.13)	-0.08	(0.14)	0.00	(0.13)	-0.04	(0.15)
South	0.22	(0.19)	0.16	(0.19)	0.16	(0.19)	0.21	(0.20)	0.20	(0.21)
Pre-Roe abortion law			0.06	(0.15)	0.07	(0.15)	0.14	(0.16)	0.09	(0.16)
Poverty by gender										
Male			0.38 +	(0.20)	0.35 +	(0.20)				
Female										
Need										
% Female							0.23	(0.15)		
Voter turnout by gender										
Male										
Female										
% Female legislature									0.05	(0.14)
r^2	0.128		0.225		0.201		0.151		0.123	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.10 *Continued*

	Model 5a		Model 5b		Model 6		Model 7	
	beta	se	beta	se	beta	se	beta	se
Unionization	-0.20	(0.15)	-0.19	(0.15)	-0.17	(0.15)		
Voter turnout					-0.09	(0.16)		
Democratic gov't	0.08	(0.19)	0.06	(0.18)	0.11	(0.21)		
Voter ID laws	-0.02	(0.14)	-0.03	(0.14)	-0.02	(0.14)		
South	0.21	(0.19)	0.22	(0.20)	0.20	(0.19)	0.25	(0.17)
Pre-Roe abortion law	0.10	(0.16)	0.09	(0.16)	0.09	(0.15)	0.15	(0.15)
Poverty by gender								
Male								
Female								
Need							0.25 +	(0.14)
% Female								
Voter turnout by gender								
Male	-0.13	(0.16)	-0.10	(0.15)				
Female								
% Female legislature					-0.11	(0.18)		
r^2	0.134		0.127		0.14		0.159	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 3.11 OLS regression of race variables on family planning spending per GDP (3-year avg.; N=50)

	Model 1		Model 2a		Model 2b		Model 3		Model 4		Model 5[+]	
	beta	se	beta	se	beta	se	beta	se	beta	se	beta	se
Unionization	-0.19	(0.15)	-0.08	(0.16)	-0.12	(0.17)	-0.18	(0.14)	-0.17	(0.14)		
Voter turnout	-0.11	(0.15)	0.04	(0.26)	-0.08	(0.17)	-0.12	(0.18)				
Democratic gov't	0.07	(0.18)	-0.04	(0.18)	0.06	(0.19)	0.08	(0.18)	0.11	(0.18)		
Voter ID laws	-0.03	(0.14)	-0.08	(0.16)	-0.02	(0.15)	-0.05	(0.15)	-0.02	(0.14)		
South	0.22	(0.19)	0.17	(0.18)	0.21	(0.20)	0.18	(0.22)	0.13	(0.22)	0.25	(0.18)
Pre-Roe abortion law			0.14	(0.17)	0.12	(0.17)	0.05	(0.15)	0.15	(0.16)	0.13	(0.16)
Female poverty by race												
White female			0.35	(0.36)								
Black female			-0.06	(0.27)								
Need by race												
White female					0.15	(0.15)						
Black female					-0.004	(0.13)						
% White							-0.002	(0.24)				
% Black							0.10	(0.20)				
Voter turnout by race												
White									-0.21	(0.19)	0.20	(0.14)
Black									0.14	(0.13)	-0.01	(0.13)
r^2	0.128		0.193		0.144		0.135		0.158		0.133	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

+ N = 47; See text for details.

143

Table 3.12 OLS regression of all variables on family planning spending per total social spending (3-year avg.; N=50)

	Model 1a beta	se	Model 1b beta	se	Model 1c beta	se	Model 2a beta	se	Model 2b beta	se	Model 2c beta	se
Female poverty by race												
White female	0.38	(0.26)	0.54	(0.36)	0.39 +	(0.22)						
Black female	-0.07	(0.19)	-0.29	(0.23)	0.02	(0.15)						
Need by race												
White							0.21	(0.16)	0.29	(0.19)	0.34 +	(0.17)
Black							-0.01	(0.14)	-0.19	(0.17)	-0.08	(0.12)
Gini			0.33 *	(0.15)	0.34 **	(0.11)			0.24 +	(0.13)	0.41 **	(0.12)
% 65 and older			-0.18	(0.21)	-0.29 *	(0.13)						
GDP per capita			-0.08	(0.20)					-0.06	(0.18)		
Unemployment			0.11	(0.15)					0.28 *	(0.14)		
% under 18			0.16	(0.26)								
Unionization			-0.03	(0.19)					-0.15	(0.18)		
Voter turnout			0.32	(0.27)					0.07	(0.18)		
Democratic gov't			-0.04	(0.19)					-0.03	(0.18)		
Voter ID laws			-0.16	(0.16)					-0.12	(0.14)		
South			0.15	(0.18)					0.15	(0.20)		
Pre-Roe abortion law			-0.04	(0.17)					-0.02	(0.17)		
r^2	0.121		0.362		0.278		0.041		0.297		0.200	

Robust standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

CHAPTER 4

STATE VARIATION IN POLICIES FOR PUBLICLY-FUNDED ABORTIONS

1 INTRODUCTION

Although Roe v. Wade legalized abortion at the national level in 1973, the battle between pro-choice and pro-life politics continues to rage. It was only three years later that the Hyde Amendment was passed. Outwardly anti-choice, Senator Hyde described his distaste for the new legalization of abortion: "I would certainly like to prevent, if I could legally, anybody having an abortion: a rich woman, a middle class woman, or a poor woman. Unfortunately, the only vehicle available is the... Medicaid bill" (National Women's Law Center 2017). Specifically, the Hyde Amendment states that federal funds are not to be used for abortion except in the case of threat to maternal life, or pregnancy as a result of rape or incest (Hasstedt, Sonfield, and Benson Gold 2017). Thus, even though abortion became legal through Roe v. Wade, the ability for women, particularly those reliant on public healthcare services, to access safe abortions remains limited.

Nevertheless, state autonomy provides individual states with the opportunity to develop their own policies toward public spending on abortions. Therefore, though states are required to spend public funds on abortion in the emergency situations described above, they can opt in to spend additional state funds on abortion in a wider range of circumstances. Currently, 17 states have opted for such (Figure 4.1). In this chapter, I thus investigate why some states have opted in, while others have not. In the previous two chapters I considered variation in public funding, both at large and for family planning services specifically. Public spending for abortion overlaps with these two from a definitional standpoint, yet from a societal standpoint abortion as a service and a political topic carries a very different social weight. To what extent, then, do we see similar

145

welfare state variables shaping policy for abortion spending as we did in the previous two chapters?

I answer these questions using two different methodologies: binary logistic regression and qualitative comparative analysis (QCA). This chapter thus serves two purposes. First, it extends the theoretical and methodological insights from the previous chapters to a more contentious reproductive healthcare policy, funding for abortion. As suggested previously, the literature on welfare state development has often excluded spending for both healthcare at large and reproductive healthcare specifically. Examination of spending for a reproductive healthcare service that has been and currently remains politicized and divisive (Carmon 2016; Center for Reproductive Rights 2014; Jozkowski, Crawford, and Hunt 2018; Luker 1984) is fruitful in expanding the welfare state literature. Second, it delves into the methodological debates on best practices for conducting comparative research. Scholars have made significant efforts to discuss the benefits and shortcomings of using conventional correlational-based approaches (regression) in small-N studies of the welfare state (see e.g. methodological symposium in Mjöset and Clausen [2007]). By analyzing my data with QCA alongside logistic regression, I can offer a contribution to this well-developed body of literature.

2 THEORY

As in previous chapters, here I employ general theories of welfare state development alongside gendered and racialized notions of the ways in which policy formation occurs within the U.S. context. A summary of hypotheses can be seen in Table 1.1.

2.1 Conventional Theories of Welfare State Development

Scholars of the welfare state identify two main arguments for why certain states develop more robust social spending programs than others. First, functional scholars maintain that state wealth in large part drives funding, with the understanding that a state requires a large enough economic surplus in order to consider investing those funds back into its population for social services (Cutright 1965; Wilensky 1975). These authors also highlight the role that need plays in shaping policy outcomes, with the understanding that policy should reflect the needs of the populace. Thus, we expect states with greater wealth, as well as higher need for abortion services to provide more liberal abortion policy (*H1*).

The second set of arguments for a developed welfare state concerns the political space and previous policy decisions (Barrilleaux and Berkman 2003; Cauthen and Amenta 1996; Quadagno 1987, 2004; Skocpol and Amenta 1986), as well as the extent to which citizens can collectively bargain to enact on their political rights (Korpi 1989; Quadagno 1987; Skocpol and Amenta 1986); what Huber and Stephens (2010) term the "power constellation" theory. One means of bargaining often studied is the extent of unionization, with the expectation that better union representation will result in state policy that more directly addresses its citizen's collective needs. Another avenue considered is the extent to which citizens use their right to vote to shift policy in their favor. Thus, we might expect that higher levels of unionization and voter engagement, particularly on the part of women, would be favorable to more liberal abortion policy (*H2*). However, given the divisive nature of the abortion question, perhaps this is only true in states with an already more liberal populace.

Related closely to the extent to which citizens enact on their power is the political space in which these decisions are being made and implemented. This includes attention to political

party domination, with the Democratic party tending to offer more generous funding for social programs in the U.S. case (Quadagno 1987). Going beyond party, scholars also indicate the role that historical political legacies can play in shaping more recent policy outcomes (Quadagno 2004; Skocpol and Amenta 1986). We thus expect that states who have historically been more favorable towards liberal abortion policy would remain as such. These scholars also highlight the historical exceptionalism of Southern Democrats as well as the South's slavery-based economy as shaping divergent social policy outcomes (Gordon 1994).

More recent political science scholars call for the importance of considering the influence of public opinion on policy decisions (Brooks and Manza 2006b, 2006a; Grammich, DaVanzo, and Stewart 2004; Kail and Dixon 2011). In particular, in Burstein's (2003) review, the author indeed finds a close link between public opinion and public policy. This may perhaps be even more true for policies set at the state level, given the relatively tight relationship between a populace and a locally-elected official necessary for reelection (Cook et al. 1992; Jelen and Wilcox 2003). Authors such as Norrander and Wilcox (1999) and Wetstein and Albritton (1995) also find a close link between public opinion and policy around abortion access, suggesting that states whose populace are more opposed to abortion will have more restrictive policy.

All together, this body of research suggests that states that have a more liberal legislature and citizenry (*H3*), as well as greater engagement on the part of citizens (*H2*), will have an expanded welfare state. For a topic as politically charged as abortion, I would particularly expect these to be driving factors in shaping state policy.

2.2 Abortion in the Welfare State

Scholarship reflects the depth to which the various theories of welfare state development described above apply to public spending policy, both globally and within the U.S. Nevertheless, a space remains to be filled in terms of how these policies apply to a policy as historically, and currently, controversial as abortion. On the one hand, public spending for abortion falls under the general umbrella of social services to be provided by the state in order to ensure women's equal social rights (Center for Reproductive Rights 2011; Luna and Luker 2013). In this way, we would expect theories of welfare state development to sufficiently explain state funding decisions. On the other hand, the moralistic nature of the abortion debate complicates the role that the state plays in both providing for its citizens and responding to its citizens concerns. Perhaps, then, we might see political factors play a different role in the formation of abortion policy than in other public funding decisions. In particular, the role of religious groups in shaping the pro-life movement as well as political discourse on the topic (Blanchard 1994; Greenhouse and Siegel 2012; Pew Research Center 2013) suggests that religiosity may play an important factor, with states whose residents consider themselves to be more religious offering more restrictive abortion policy.

Additionally, abortion policy and practice in and of itself is very much a gendered and racialized phenomenon. Thus, it remains relevant to consider the roles that gender and race play in shaping abortion policy. As with policy for reproductive healthcare more broadly, the U.S. has a long history of using reproductive policy as a means for driving racial inequalities. Whether this exists through forcing or coercing women of color to undergo sterilizations (Amnesty International 2010; Borrero et al. 2014; Joffe and Parker 2012; Volscho 2010), or in explicitly limiting their access to vital reproductive healthcare (Howell and Starrs 2017), scholars on both

sides highlight the unequal treatment of women of color compared to White women surrounding abortion. This research reflects the possibility of both more and less restrictive abortion policy based on the needs of women of color, so we should at the very least expect a difference in the extent to which policy reflects White versus Black women's needs. In addition, given the arguments within the larger welfare state literature surrounding racial representation within a state, the overall proportion of Black women may play a role in shaping abortion policy, such that with greater representation, states are indeed more restrictive of their abortion policy, based on the "threat" hypothesis (Key 1949). In this way, we expect states to be more responsive to the reproductive needs and representation of White women over Black women (*H6*).

In addition, Feminist scholars of the welfare state highlight the importance of a developed welfare state in addressing the needs of all citizens, regardless of gender (Bacchi 1999; Lewis 1992; O'Connor, Orloff, and Shaver 1999; Orloff 1996; Sainsbury 1996). In examining a topic that is not only inherently gendered, but which also taps into citizen's broader ideologies around gender equality (Bolzendahl and Myers 2004; Jelen and Wilcox 2003), I draw on this literature. Specifically, these authors suggest the positive role that female political representation plays in shaping gender-related policy outcomes (Bolzendahl and Brooks 2007; Paxton, Green, and Hughes 2008; Poggione 2004). Given the gendered nature of abortion and its role in the women's rights movement (Rohlinger 2002; Stetson 2001), we might expect that states with higher counts of female state legislatures would be more likely to develop and pass more liberal abortion policy (*H5*). In addition, state policy should be more reflective of the needs and presence of women as compared to men (*H4*).

3 DATA AND METHODS

A note on terminology: regression and QCA, while overlapping on their use of the data, use different terminology to describe the social phenomena being tested. Briefly, whereas in regression we have variables, dependent variables, and independent variables, in QCA we consider conditions, outcomes, and causal conditions. For the descriptions here, I employ regression-based terminology for simplicity. When describing QCA methodology and results, I will use QCA terminology.

3.1 Data

Data for this chapter come from a variety of publicly available sources from the year 2014, unless otherwise noted. A full list of variables/conditions and their descriptive statistics can be seen in Table 4.1.

3.1.1 Dependent Variable

The variable I am interested in investigating in this chapter is whether or not a state chooses to cover abortion costs for Medicaid recipients, outside of those emergency circumstances dictated by federal policy, in the year 2015. This data is available historically from the Guttmacher Institute (GI), and more recently from the National Women's Law Center. The original data from GI groups states into two categories, with two subcategories each. In the "nonrestrictive" abortion policy group, states confer public funds for abortion in medically necessary circumstances beyond those mandated by federal law. This first group is further divided into states that opt-in voluntarily, and those that have been mandated to do so by their state courts. In the "restrictive" abortion category, states only offer public funds in the federally-

mandated restrictive circumstances. The majority of restrictive states fall under this category, with two exceptions. First is South Dakota, which is currently in violation of federal law,[1] second are a collection of states that marginally expand eligibility to include circumstances of, e.g. fetal anomaly.

This outcome is chosen in part because of its use by previous scholars of state support for abortion access, in particular its relation to public opinion and political processes (Barrilleaux and Berkman 2003; Berkman and O'Connor 1993; Meier and McFarlane 1992; Norrander and Wilcox 1999). However, as others (Medoff 2012; Medoff and Dennis 2011) note, the validity of this measure debatable. Specifically, these authors offer concern for the fact that "nonrestrictive abortion policy" combines states that expand their coverage voluntarily with those that are court-ordered. Medoff (2012:242) argues that "there is a question of causality using state funding of Medicaid abortions as a measure of a state's abortion policy since the main source of variation for a state funding Medicaid abortions are state Supreme Courts." This is why, he suggests, finding significant predictors of nonrestrictive Medicaid abortion policy is difficult, and thus opts instead to use state Targeted Regulation of Abortion Providers (TRAP) laws[2] as a more robust outcome.

Although measurements of TRAP laws cover a wider range of policies, here I have chosen to look solely at public funding for abortion for two reasons. First, to be consistent with the welfare state literature that considers spending as an outcome, investigating spending for abortion in this chapter remains appropriate. Second, because I am using QCA which allows for asymmetrical relationships, it is possible that I may find predictive factors to be "significant" that

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[1] Abortion is only covered by public funds if the woman's life is at risk.
[2] TRAP laws are a series of legislation passed by the states that inhibit a woman's access to abortion services. Examples include mandatory waiting periods, ultrasounds, and counseling, among others, prior to receiving an abortion.

do not appear as such in conventional regression analyses. For this analysis, I use a binary outcome, where "1" indicates that the state has restrictive abortion policy (has failed to expand their spending for abortion) and "0" reflects states with nonrestrictive abortion policy. This truncation is done for two reasons: first, for simplicity of analysis; second, without further investigation into the court cases mandating nonrestrictive policy I am hesitant to treat these groups as categorically different.

3.1.2 Independent Variables

The independent variables for this project are based on the set of welfare state theories described above. To represent functional controls of welfare state spending, I include several variables: *GDP per capita*, *Gini coefficient*, *unemployment rate*, *age*, and *poverty*. *GDP* data comes from the Bureau of Economic Analysis and is measured in millions of dollars. The *Gini* coefficient is a measure of state income inequality that ranges from 0 to 1, with higher scores indicating less equality. Next, *unemployment rate*, *percent of population under 18* and *over 65*, and *poverty* levels are included to capture the extend of need within the state.

In my second set of models, I include conventional variables related to the power/political perspective of welfare state development. *Unionization* comes from the Bureau of Labor Statistics and percent of employed who are members of unions. *Voter participation* measures the percent of citizens who are 18 years of age or older who voted in the previous presidential election, as shown in the Current Population Survey. To capture political factors associated with welfare state spending I first test four measures related to government and policy: *Democratic government*, *voter ID laws*, *South*, and *pre-Roe abortion legislation*. *Democratic government* is a scale constructed from data from the Book of States based on the

governor's party (Democratic or Republican) and majority party of the state legislature (Democratic, Republican, or Split). *Voter ID laws* is a 5-point scale indicating type of voter ID law (or whether there is such a law) within a state.[3] Finally, *South* and *pre-Roe abortion policy* are included to capture the historical economic and political distinctions of Southern vs. Northern Democrats as well as the legacy of early abortion legislation on current policy decisions. *Pre-Roe* is dichotomized to represent states in which abortion was legal in some or all circumstances (1) or illegal (0).

Second, given the connection between public opinion and policy, particularly within a state context (Burstein 1998, 2003; Cook et al. 1992; Jelen and Wilcox 2003), I include a series of aggregated opinion variables. First, *liberal political ideology* is taken from Berry et al.'s (2010) scoring of citizen ideology within a state. This measure is based on a series of factors, including "using the roll call voting scores of state congressional delegations, the outcomes of congressional elections, the partisan division of state legislatures, the party of the governor, and various assumptions regarding voters and state political elites" (Berry et al. 1998:327). These measures have undergone several checks of robustness and validity (Berry et al. 1998, 2010) and are used throughout the political science literature. The next set of measures comes from Pew Research Center's 2014 Religious Landscape Study. Conducted in 2007 and 2014, the Religious Landscape Study offers a nationally-representative sample of responses relating to among other social issues, abortion and religion. Though several other surveys target opinion on similar topics, most notably the General Social Survey, few others offer data at the state level. As such, this data is ideal for the study of abortion policy and opinion in the context of this project. Specifically, I include a measure of the percent of people within a state who *support legal*

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[3] Specifically, where: 0 = none; 1 = non-strict non-photo ID required; 2 = non-strict photo ID required; 3 = strict non-photo ID required; and 4 = strict photo ID required

abortion in some or all forms, as well as a series of variables targeting the level of religiosity within a state. These include the percent of citizens who identify as *Evangelical*, *mainline Protestant*, or *Catholic*, as well as average *importance of religion* within the state, with higher values indicating higher religiosity.

In additional models, I consider the extent to which gender and race shape the impact of some of these power and political factors. Specifically, I disaggregate *poverty by gender*, and then *female poverty by race*. I disaggregate *voting by gender* and *race*[4] as well, and include population proportions representing the *percent of women*, *percent White*, and *percent Black* within the state. To capture the importance of female political representation, beyond political engagement of the citizen, I include the *percent of women in state legislature* from the Center for American Women in Politics.

Another variable related to female poverty, *need for publicly funded contraceptive services*, is considered here as well. *Need* is taken from the Guttmacher Institute's regular report on contraceptive needs and services (Frost, Frohwirth, and Zolna 2016). This measure takes into account census data such as age and income, alongside data from the National Survey of Family Growth indicating likelihood of becoming pregnant alongside desire to not have a child. Together, this measure captures the number of women in need of publicly funded contraceptives, as a percent of the total number of women in need of contraceptives in a state. Even though this chapter's main focus is abortion, this measure of need serves as an appropriate proxy for considering the extent to which a state has a high proportion of women who are: 1) sexually active; 2) not wanting to have children; and 3) living below the poverty level. *Need* is included overall, as well as *disaggregated by race* (White and Black).

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[4] Black voting data is unavailable for ID, MT, and SD; these states are excluded from analysis for those models that employ this variable.

3.2 Methods

Two different methodological techniques are pursued in this chapter: binary logistic

regression and qualitative comparative analysis (QCA). As mentioned in Chapter 1, debate

abounds as to the most valid and reliable ways of observing and analyzing variation in social

spending between states. Regression remains the standard, yet limitations exist of the extent to

which correlation-based techniques can capture the picture of what is going on, particularly with

the small-N cases often presented to scholars of the welfare state. Where regression offers mean-

centered analysis of correlations, QCA treats each state as an individual case, allowing

relationships to be asymmetrical. In addition, through QCA I can better examine the overlapping

relationships between "independent variables" or "causal conditions" as they relate to my

outcome, a state's failure to opt-in to use of Medicaid for abortion.

3.2.1 Regression

The regression technique I pursue is binary logistic regression, based on the outcome of

whether a state fails to opt-in to expanded coverage of abortion for Medicaid recipients. Because

I am looking at a single time point (based in part on data availability), I am restricted by my

number of cases, 50. Thus, although I build up models in a manner similar to Chapter 2, my

combined models are limited in the number of variables, particularly given logistic regression's

sensitivity to multicollinearity.

I thus present three sets of models. The first regresses conventional functional and

power/political variables on the outcome. A parsimonious model is developed here using single

elimination based on amount of explained variance of each variable. Next, I incorporate

variables such as poverty and voting rate disaggregated by gender and race into the parsimonious

156

power/political model. Whereas in previous in chapters I combined certain characteristics together in a "full" model, the lack of explanatory power prevents me from doing so here. All regression analyses are done using Stata 13 (StataCorp 2013).

3.2.2 QCA

QCA applies a Boolean algebra approach to the study of comparative welfare states. Utilizing logics from set theory, QCA considers the extent to which states occupy overlapping sets of conditions. For example, for my outcome, I am interested in the set of states that have restrictive abortion policy. As a second condition, say I am interested in the set of states that have a low percent of citizens in favor of legal abortion. With QCA, I can determine the states that fall within both of these sets, and in this way, explore the extent to which low support for legal abortion is a *necessary* or *sufficient* condition for a state having restrictive abortion policy. In addition, I can repeat this process with simultaneous evaluation of multiple conditions, allowing me to examine the extent to which a specific *combination* of conditions is necessary or sufficient for my outcome. I thus use QCA here to test the theoretical paradigms described above. Furthermore, QCA takes a hybrid approach to the study of comparative welfare states, drawing from both qualitative and quantitative paradigms (Ragin 2008; Rubinson and Ragin 2007). In this way, the theories presented above can be tested inductively through the QCA algorithm.

From a case-oriented perspective, knowledge of the cases (in this project, the 50 states) is vital in constructing the conditions used in exploring causal links of restrictive abortion policy. I thus take the variables described above, representing various theoretical approaches to the study of welfare state development, and use them to construct fuzzy sets to be tested with QCA. The

157

process of constructing these fuzzy sets through calibration is grounded in knowledge of the case, as well as a theoretical understanding of what represents, for example, low vs. high GDP in the context of the U.S. The calibration itself takes place in the fsQCA software, based on cutoffs for full, partial, and null membership within each set (condition) as decided by the researcher.[5]

The first step in conducting QCA is to decide on the set of cases. In this project, my selection is based on wanting to comprehensively examine variation across all U.S. states. Therefore, case selection is straightforward in that I am including all fifty states.[6] Next, conditions are calibrated using a theoretical understanding of the measures alongside case knowledge, as well as the data itself. This process allows for the conversion of categorical or continuous measures into sets, and is importantly descriptive: e.g. *high* levels of poverty, rather than just poverty. Calibration is conducted by choosing three cut-points, or values representing: 1) total inclusion in the set; 2) a crossover point between more in than out of the set; and 3) total exclusion from the set. Inputting these values into the fsQCA software allows me to convert those continuous or categorical variables used in the logistic regressions described above into fuzzy set conditions.

Once conditions have been calibrated, I follow the four steps of the fuzzy truth table algorithm using the fsQCA software: 1) explore whether specific conditions are necessary and/or sufficient for my outcome; 2) test various combinations of conditions using the subset/superset procedure; 3) construct and pare down the truth table; and 4) analyze the truth table. I conclude by evaluating membership in the intermediate solution set using a logistic regression predicting my outcome, restrictive abortion policy.

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[5] Table 4.5 shows the cut-points used for each of the conditions tested here.
[6] This excludes Washington DC.

In order to be consistent with the logics of the regression analysis, preliminary steps (1-2) are conducted based on each condition's theoretical groundings from the welfare state literature. Based on these results, I select a set of conditions to analyze in combination. These include *Black female poverty*, *unionization*, *Democratic government*, and *female legislative representation*. In doing so, I target not only the extent to which different theoretical frames help explain my outcome, but also whether a combination of different aspects of these perspectives is more suitable. All analyses are done using the fsQCA software, version 3.0 (Ragin and Davey 2017).

4 FINDINGS

4.1 Descriptive Results

Overall, 33 out of the 50 states maintain restrictive abortion coverage; that is, fail to offer public funds in cases of abortion outside of those mandated by federal government. The map in Figure 4.1 reflects these findings. We see several differences in values of the independent variables by abortion policy status (Table 4.1). Most notably, those states with more restrictive abortion policy have higher levels of need, both overall and by race, for publicly funded contraceptives (Figure 4.2). These findings suggest that state abortion policy may not be particularly reflective of the reproductive needs of their female citizens. Simultaneously, there seems to be policy differences based on the public opinion of individuals within those states (Figure 4.3). Specifically, we find that states with restrictive abortion policy have significantly more Evangelical Protestants and fewer respondents in support of abortion. Interestingly, these states also have significantly fewer Catholics.
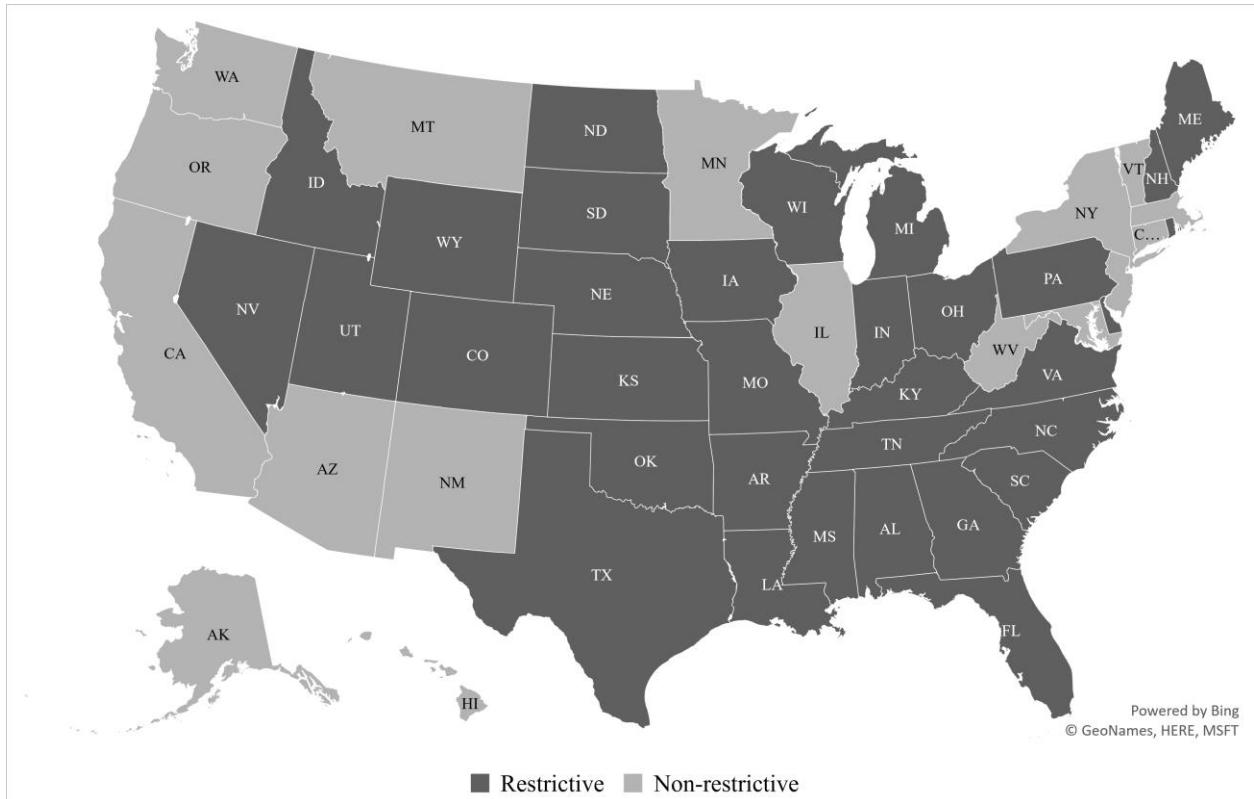
Figure 4.1 Restrictive abortion coverage by state, 2014
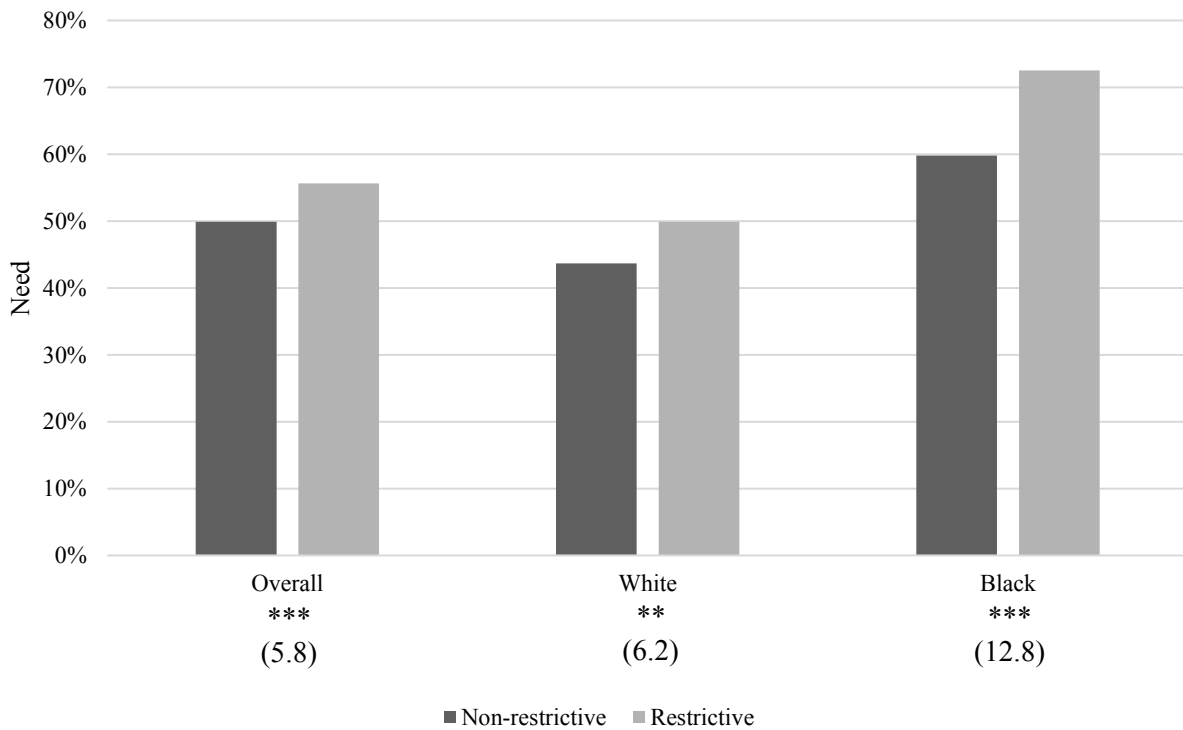
Figure 4.2 Need by race and abortion policy (differences in parentheses)

160
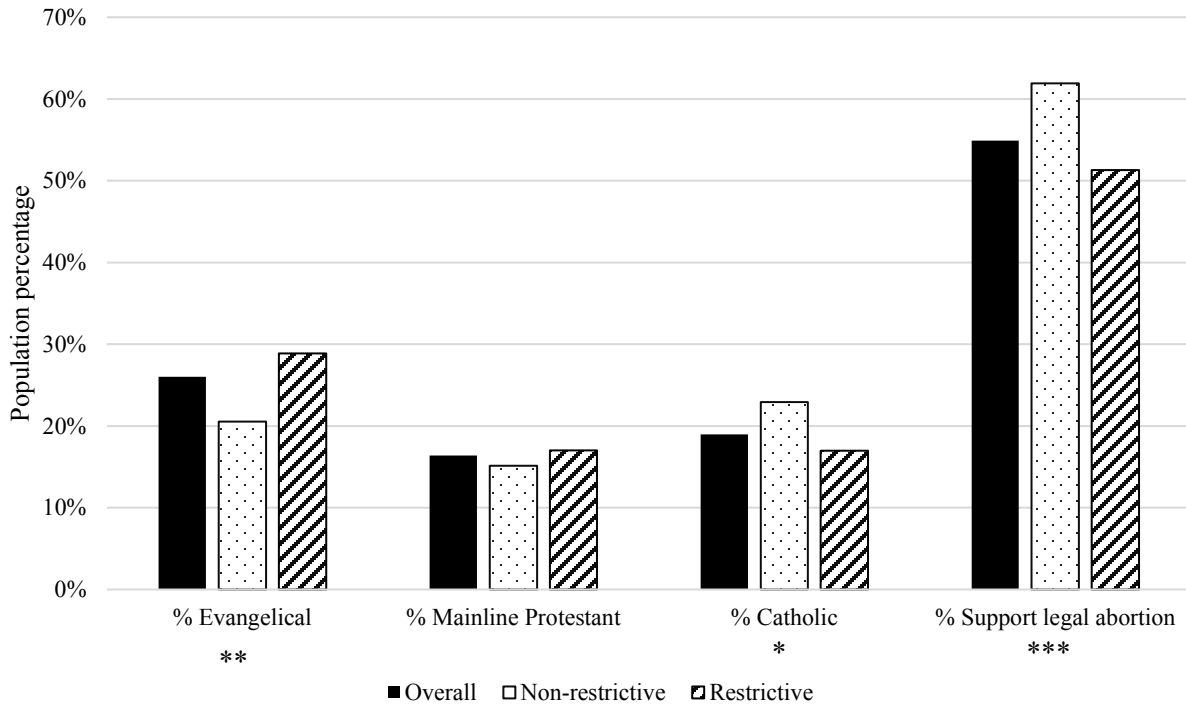
Figure 4.3 Average religion and abortion opinion by abortion policy type

4.2 Regression Results

Next, I turn to inferential results. First, I present results from the binary logistic

regression analysis described above in Tables 4.2-4. The first set of models examines the role of

conventional functional and power/political variables in shaping spending outcomes (Table 4.2).

Interestingly, of the standard set of functional variables used previously in this project (Model 1),

none are significant. Of conventional power/political variables, *unionization* and *Democratic*

government seem to be most highly correlated with the outcome, and both negatively so (as

expected). Of opinion measures, only *religiosity* is significantly, positively, associated with the

outcome, and this only marginally so. When these three significant variables are incorporated

into a single more parsimonious model, *religiosity* indeed loses its significance.

Moving on to Table 4.3, I incorporate measures related to the gendered aspects of power

and political engagement. Here we fail to see significant associations between any of my

variables and the outcome. Notably, *female legislative representation* is not significant, yet its

explanatory power can be seen in that Democratic government loses significance and

unionization becomes only marginally significant. The direction of this variable is as expected,

with higher levels of female political representation associated with less restrictive abortion

policy. Similarly, Table 4.4 shows the race variables to show little significant effect as well.

White and *Black population proportions* are both significant, but in the same direction,

obfuscating any real connection between them and the outcome. *Black voter turnout* is

marginally positively associated with more restrictive abortion policy, tapping into a debate on

how respondent race may impact opinion on abortion (Carter, Carter, and Dodge 2009; Hall and

Ferree 1986; Wilcox 1990, 1992). Notably, although female poverty by race fails to show

significant differences, *overall poverty by race* reflects a marginally positive association between

Black poverty levels and more restrictive abortion policy. Similarly, separating White and Black

need into different models shows Black women's needs to be positively associated with more

restrictive policy.[7]

4.3 QCA: Preliminary Findings

My first step in analyzing this data using QCA is to examine the consistency and

coverage for necessity for each condition individually (that is, the extent to which a condition is

necessary and/or sufficient for my outcome). Table 4.6 shows consistency and coverage scores

for necessity for each condition, as well as its negation, by theoretical framework. In examining

conditions derived from the functional perspective, we do not see any that are particularly high in

consistency. The highest ranking is a lack of high *GDP per capita*, a condition that also has

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[7] Results not shown.

decent coverage. Moving on to class power conditions, a lack of high *unionization* ranks

markedly high in consistency for necessity, suggesting this condition is a shared antecedent with

restrictive abortion policy. A lack of a *Democratic* government also has a somewhat high

consistency score, and its coverage is highest among these conditions. Interestingly, although

overall *religious importance* has a somewhat high consistency score, a lack of high *Protestant*

and *Catholic* representation also have relatively high consistency scores, though less-so.

Taking gender into account yields mixed results. The highest scoring condition here on

both necessity and sufficiency is a lack high *female legislative representation*, supporting

gendered notions of the welfare state. This finding is countered by the somewhat high

consistency score of high *female voting participation*. We also see relatively high consistency

scores for high *female poverty* and *need*, suggesting that abortion policy may not be entirely

reflective of need. When these *need* and *poverty* measures are *disaggregated by race*, the

relationship between high Black female poverty and need and a state's restrictive abortion policy

becomes particularly salient. High Black female poverty yields the highest consistency score of

all conditions, with a sizable coverage score as well. When examining high White poverty and

need, we see that a lack of both has higher consistency scores than the presence of either,

reiterating this relationship.

Based on these scores, I proceed with the subset/superset analysis, the results of which

can be seen in Table 4.8.[8] For functional factors, results overall do not reflect particularly high

sufficiency. The highest sufficiency score comes in at 0.71, a three-way tie between

combinations of conditions that all include a lack of high *GDP per capita*. The highest coverage

score indeed is lack of high GDP per capita on its own. Conventional power/political conditions

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[8] Conditions were selected based on their high consistency scores for necessity and for theoretical contributions.

yield more fruitful results. The two recipes with the highest sufficiency scores thus far (0.91) are

1) high *religiosity* and a lack of *unionization* and 2) high *religiosity* and a lack of *unionization*

and *Democratic government*, both of which yield relatively high coverage scores as well. In

addition, lack of unionization retains the highest coverage score thus far, reflecting results from

Table 4.6. These first findings suggest the importance of political factors, as well as public

opinion and engagement, in shaping abortion legislation.

Next, in examining gendered power/political conditions, results are not as strong, though

we do see somewhat high sufficiency scores. A lack of high *female political representation*

appears to contribute to almost all of the highest-scoring recipes. Interesting, high *need* and high

poverty once again appear to counterintuitively overlap with more restrictive abortion policy.

When these measures are further *disaggregated by race*, sufficiency scores become more

middling, the highest being 0.67. Nevertheless, high Black need, and especially high Black

female poverty yield particularly high coverage scores, suggesting that like a lack of high

unionization, high Black female poverty is a shared antecedent of restrictive abortion policy.

Given the utility of QCA in considering the extent to which combinations of specific

factors lead to an outcome, I next test how individual factors from each of these paradigms might

overlap in their effects on shaping abortion policy. Indeed, when examining scores in Table 4.7,

we see both gendered and racialized factors having high necessity scores, alongside more

conventional power/political factors. Specifically, *Black female poverty* and *need* for publicly

funded contraceptives remain highly ranked, as does a lack of *unionization* and *female political*

representation. The highest-scoring functional condition, on the other hand (a lack of high *GDP*

per capita), falls lower at 0.70. Using the subset/superset feature to further explore the

combinations of the most necessary conditions (Table 4.8), we see that the combination of *Black*

female poverty with a lack of *female* and *Democratic political representation* scores notably high on both sufficiency (0.93) and coverage (0.70), particularly given the binary operationalization of my outcome. Lack of unionization also appears frequently in this series of causal recipes.

4.4 QCA: Truth Table and Solution

Moving on to the last two steps of the QCA algorithm, a full truth table can be seen in Table 4.9. Based on the analysis of necessary conditions and the subset/superset procedure, the conditions I examine here include high *Black female poverty*, high *unionization*, majority *Democratic* governmental representation, and high *female political representation*. Notably, the intermediate solution includes all four conditions, with presence/absence of each condition appearing as expected. This solution calls for high *poverty among Black women* combined with a lack of *unionization* as well as a lack of *female* and *Democratic political representation*. The sufficiency score for this solution ranks high (0.94), and the solution offers a high coverage score (0.69) as well. In the parsimonious solution, the *unionization* term is removed from the recipe.[9] As such, these solutions highlight the utility of combining factors from multiple theoretical frames, as well as the continued importance of racial political and power mechanisms in shaping outcomes on abortion policy.

The results from the truth table are visualized in Figure 4.4. Here, darker shades represent higher solution consistency, and the numbers within each sector indicate the number of states with at least a 0.5 membership score in that combination of factors. In addition to highlighting

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[9] A prime implicant tie exists for the presence of Black female poverty and absence of each other factor, such that I needed to choose between presence of Black female poverty or absence of unionization combined with the other two conditions. I chose the recipe containing Black female poverty on theoretical grounds; choosing the other solution shows lack of high unionization to be the third condition present in the parsimonious solution.
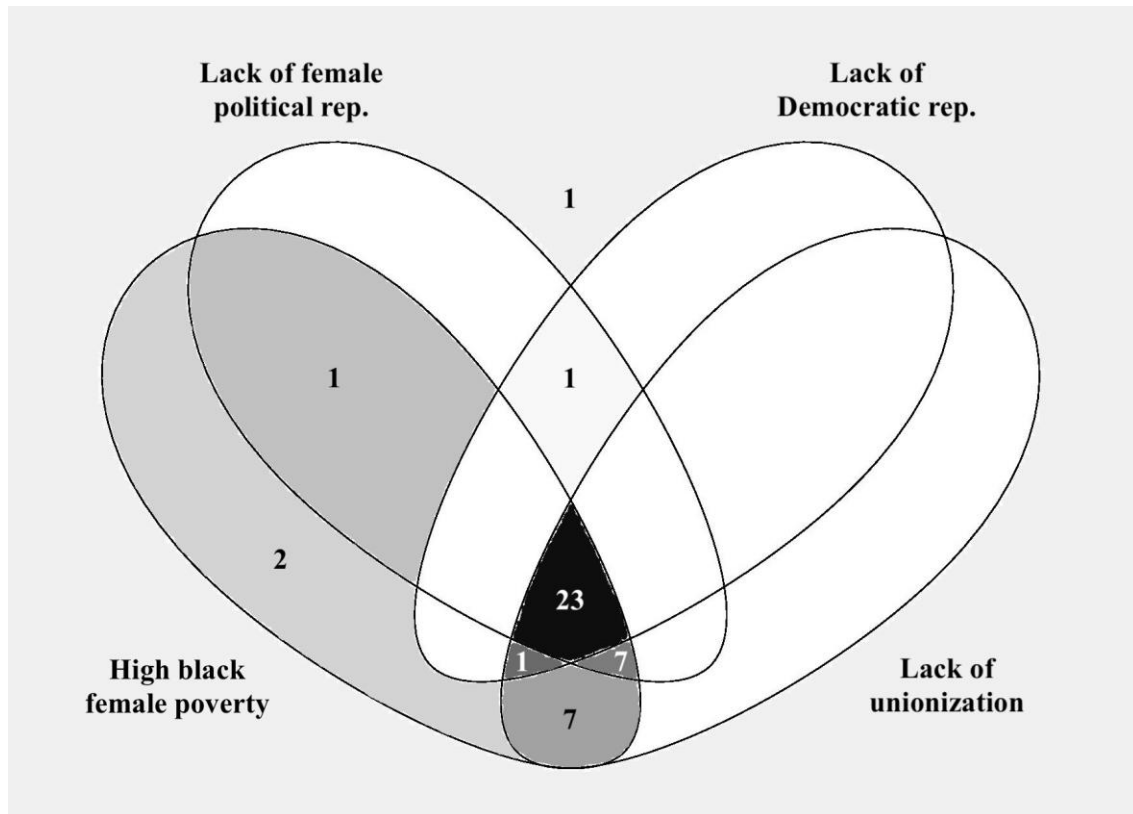
Figure 4.4 Venn diagram of intermediate solution and case distribution (darker shades represent higher solution consistency)

the intermediate solution results, this chart helps us recognize that there appears to be a variety of paths for states who have less restrictive abortion policy, but fewer for those who restrict their abortion funding. I further investigate the membership in the intermediate solution by specific states in Figure 4.5. Here we see that darker states, such as South Carolina or Oklahoma, have higher membership in the solution set, while lighter states such as California or Vermont have lower membership. In referring back to Figure 4.1, there are appropriate overlaps between these states and their abortion policy.

I test this more rigorously by conducting a logistic regression of the outcome using membership in the intermediate solution as my independent variable. The results of this can be seen in Table 4.10 and visualized in Figures 4.6-7. From the regression results we recognize a positive, significant association between solution set membership and restrictive abortion policy.

166
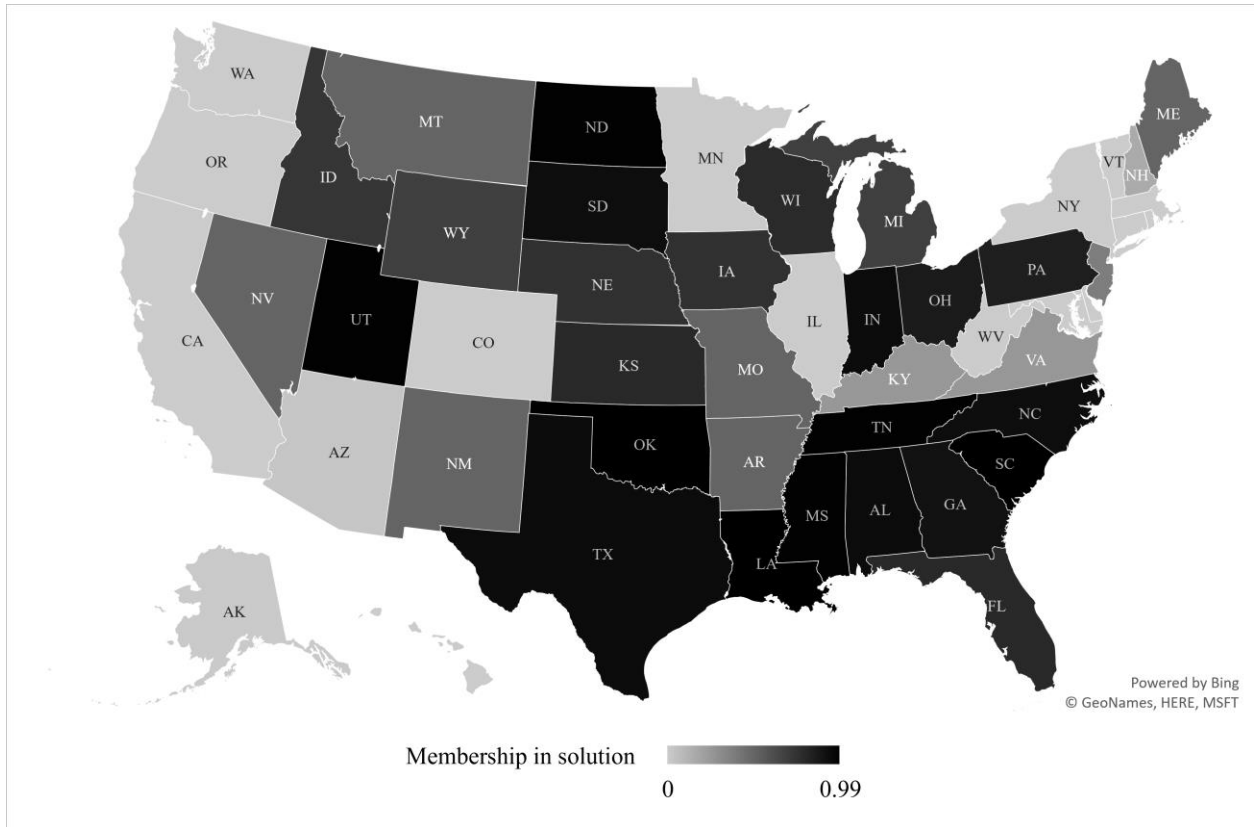
Figure 4.5 Map of membership in intermediate solution set: high Black female poverty combined with lack of high unionization, lack of high female political representation, and lack of high Democratic political representation (0 = non-membership, 1 = full membership)
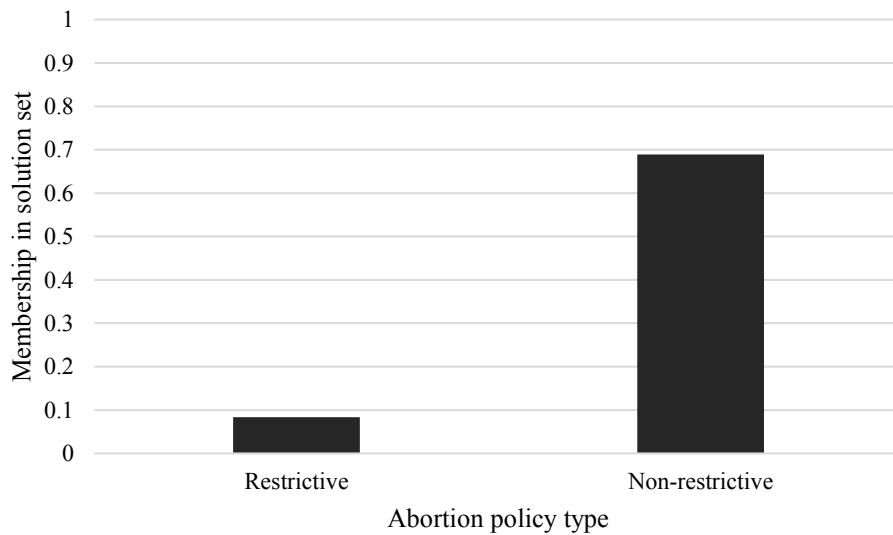
Figure 4.6 Membership in intermediate solution set by abortion policy type
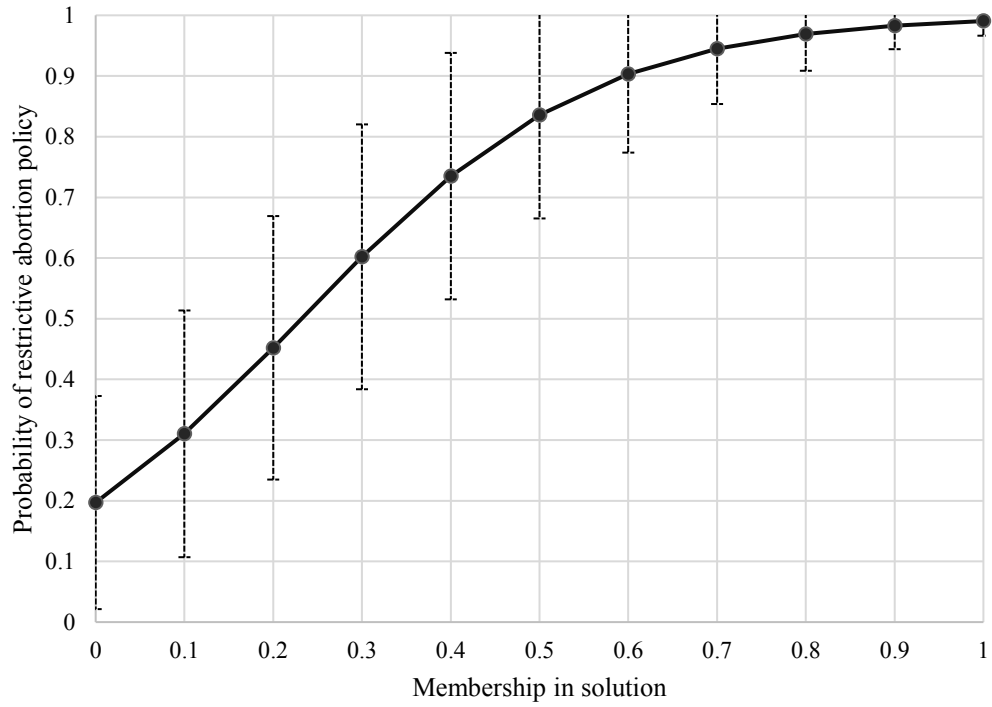
Figure 4.7 Probability of supporting restrictive abortion policy by membership in the solution set
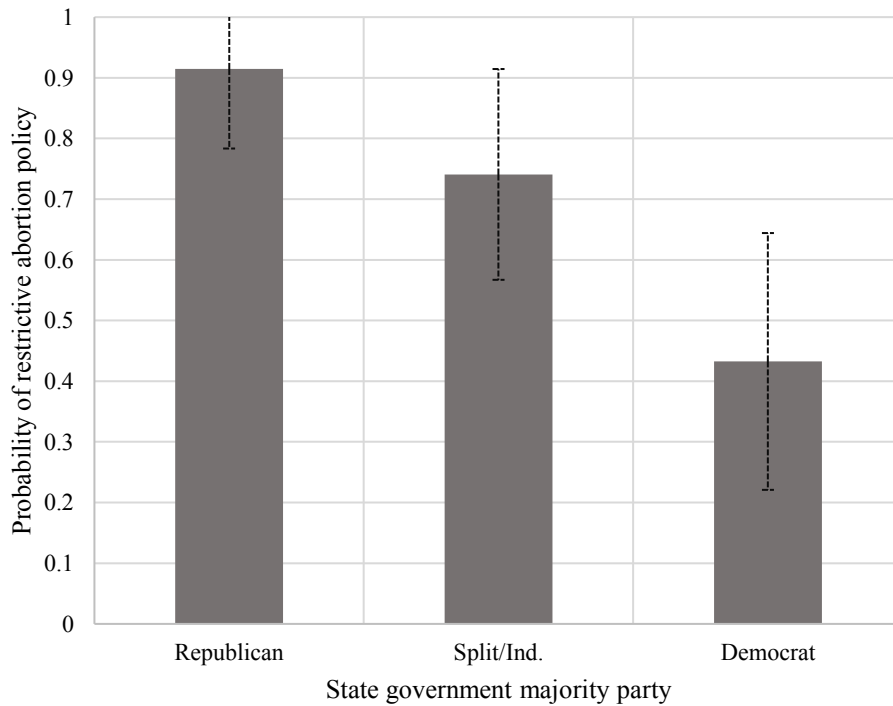
Figure 4.8 Probability of supporting restrictive abortion policy by governmental majority party

Indeed, the average membership scores for the two policy groups are both meaningfully and significantly different from each other (Figure 4.6). Calculating predicted probabilities reiterates this finding (Figure 4.7) as we see the upward trend in probability of supporting restrictive abortion policy (y-axis) with an increase in set membership.

5 DISCUSSION AND CONCLUSION

In this chapter, I examine the extent to which conventional measures of welfare state development explain differential abortion policy across the U.S. Although spending for abortion in some ways falls under traditional studies of social welfare and spending, given its characterization as a particularly politically- and religiously-charged topic, a question remains as to the extent to which these conventional explanatory factors hold up in studies of abortion spending. I thus proceed by running a series of binary logistic regression models considering how these conventional factors affect the odds of a state having more restrictive abortion funding policies. In addition, I incorporate specific variables related to the racialization of abortion policy to determine the extent to which racialized theories of the welfare state, specifically the "threat" hypothesis, is reflected in abortion policy.

Overall, regression findings offer only middling support for the majority of conventional welfare state measures. One exception is role of unionization and Democratic governments in passing less restrictive abortion policy. Predicted probabilities based on varying levels of Democratic government (Figure 4.8) reveal the downward probability of boasting restrictive abortion policy as Democrats gain power. However, given the strength of these political and power factors in shaping policy outcomes, we fail to see the significant relationship between poverty and policy on publicly-funded abortions that was so present in previous chapters. This is

further carried out in the association's failure to reach meaningful significance when poverty is disaggregated by gender and/or race. This counters some of those results seen in previous chapters, as well as what would be suggested by racialized and gendered perspectives on welfare state development.

Another goal of this chapter is to evaluate conventional regression techniques alongside one alternative approach to comparative welfare states, QCA. In order to parallel the logistic regression, I first conduct analyses of individual conditions based on each theoretical paradigm individually. Though useful in identifying those individual conditions within each framework that offer the highest consistency scores, taken individually, the causal recipes were somewhat limited in their explanatory power. Between functional and power/political solutions, the latter yield the higher consistency and coverage scores, suggesting the utility of citizen engagement in explaining state abortion policy, as well as the ubiquity of the political conditions in doing so.

Combining various conditions from each of the three paradigms proves beneficial in constructing causal recipes. From this analysis we also find the persistent role of Black female poverty, among other factors, in shaping abortion policy. Specifically, in all three iterations of this final set of solutions, high female poverty is shown to be one of the necessary conditions for a state having restrictive funding for abortions. The intermediate solution of high Black female poverty, combined with a lack of high unionization and Democratic and female representation, proves robust to further analysis using logistic regression.

These findings reflect a lack of recognition on the part of policymakers on women's reproductive needs, and in particular the needs of Black women experiencing poverty. Scholars of the racialized welfare state describe the role of Black representation in shaping policy outcomes (Brown 2013; Reese, Ramirez, and Estrada-Correa 2013); yet this finding is suggestive

170

of an additional political mechanism. That is, the extent to which state policy is differentially

responsive to citizens' needs by, in this case, race. In suggesting that state policy is at best not

impacted by women's needs, and at worst in opposition to (Black) women's needs, this study

highlights the role of the state in perpetuating race, class, and gender inequalities. In doing so, it

emphasizes the importance of considering race and gender alongside class in studies of the

welfare state. For future work, consideration of opinion disaggregated by race might be helpful

in further elucidating mechanisms for the race effects observed here.

Comparison of regression results to QCA results also provides useful information in

debates on how to best establish causation within the welfare state literature. First, we see that

certain "significant" variables overlap with highly "necessary" conditions, such as unionization

and Democratic representation. At the same time, the conclusions we draw from the two methods

are slightly different. The regression results, for example, allow us to calculate predictive odds of

a state adopting more restrictive abortion policy, based on the series of independent variables

included here. Yet they are limited given the sample size and issues with collinearity. QCA

results, on the other hand, highlight the overlapping nature of these variables, or conditions, in

identifying states with restrictive policy. In addition, through QCA we observe the fact that

although several pathways exist to having more robust abortion policy, fewer lead to restrictive

policy. This suggests the utility of taking a range of approaches to expanding public funding for

abortions at the state level to pro-choice advocates.

Furthermore, findings from the QCA analysis in many ways provide much larger support

for the role of the racialized welfare state in shaping abortion policy than do those from the

logistic regression. In addition to supporting the continued comparison of regression results to

alternative methods, this finding emphasizes the intersectional and combinatorial nature of

welfare state characteristics, particularly for something as socially complex as abortion. Other scholars (Nalepa and Gran 2018) have applied QCA to comparative studies of abortion policy, and future research would do well to continue on this trend.

Together, these two methods provide rich information in our attempts to better understand variation in abortion policy between U.S. states. In this way, this chapter expands the literature on welfare state development to a complex social topic, abortion. Nevertheless, there are several avenues for expansion and improvement. First, although this project uses a dichotomized outcome to describe state abortion policy, variation exists between states in their exact abortion policies (for example, distinguishing between those states that voluntarily opt in to robust abortion coverage and those that are mandated by their state courts to do so). Second, similarly, future work should incorporate other laws outside of public spending in order to capture a more holistic picture of support for abortion within a given state (Medoff 2012; Medoff and Dennis 2011). Third, a more detailed case analysis could potentially better capture when, where, and why certain states choose to restrict their abortion funding. Although few states change their policies within the time period in which this data is collected, further study of those states that do may provide a better temporal picture of catalysis of abortion restrictions.

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Table 4.1 Descriptive statistics (N = 50)

Type	Variable	Overall (N = 50)				Nonrestrictive Abortion Policy		Restrictive Abortion Policy		Difference		
		Mean	St. Dev.	Min.	Max	Mean	St. Dev.	Mean	St. Dev.	Mean	St. Error	Sig.
Outcome	Restrictive abortion coverage	0.66	0.48	0	1							
Functional	GDP per capita	0.05	0.01	0.04	0.08	0.06	0.01	0.05	0.01	0.01	0.003	+
	Gini coefficient	0.46	0.02	0.41	0.50	0.46	0.02	0.46	0.02	0.00	0.01	
	Unemployment rate	8.38	1.90	3.1	11.8	8.66	1.46	8.24	2.10	0.42	0.57	
	% under 18	23.38	1.93	19.96	31.10	22.80	1.54	23.68	2.06	-0.87	0.57	
	% 65 and older	14.03	1.68	8.55	18.17	14.02	1.83	14.03	1.63	-0.01	0.51	
	Poverty status	14.89	3.16	8.85	22.64	13.94	3.33	15.39	3.00	-1.45	0.93	
Power/Political	Unionization	10.22	5.34	1.90	24.60	14.68	5.23	7.92	3.73	6.76	1.28	***
	Voter turnout	62.65	5.83	47.8	74.5	61.70	6.44	63.15	5.53	-1.45	1.74	
	Democratic gov't	1.70	1.76	0	4	3.18	1.42	0.94	1.41	2.24	0.42	***
	Voter ID laws	1.36	1.43	0	4	0.53	0.87	1.79	1.47	-1.26	0.39	**
	South	0.32	0.47	0	1	0.18	0.39	0.39	0.50	-0.22	0.14	
	Pre-Roe abortion law	0.40	0.49	0	1	0.53	0.51	0.33	0.48	0.20	0.15	
	% Evangelical	26.03	11.03	6.56	52.13	20.53	8.00	28.86	11.41	-8.33	3.10	**
	% Mainline Protestant	16.38	5.82	5.61	31.97	15.15	5.76	17.01	5.83	-1.86	1.73	
	% Catholic	18.99	8.85	4.23	42.17	22.91	8.71	16.97	8.34	5.95	2.53	*
	Religiosity	2.20	0.22	1.66	2.63	2.06	0.19	2.27	0.21	-0.21	0.06	**
	Liberal political ideology	49.87	15.64	20.98	91.85	61.93	13.98	43.67	12.65	18.26	3.91	***
	Support legal abortion	54.91	10.05	37.63	77.32	61.91	9.39	51.30	8.42	10.62	2.61	***

+ N = 47; See text for details.

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 4.1 *Continued*

Type	Variable	Overall (N = 50)				Nonrestrictive Abortion Policy		Restrictive Abortion Policy		Difference		
		Mean	St. Dev.	Min.	Max	Mean	St. Dev.	Mean	St. Dev.	Mean	St. Error	Sig.
Gender	Poverty by gender											
	Male	16.11	3.35	9.67	24.79	14.98	3.41	16.70	3.22	-1.72	0.98	+
	Female	13.63	2.96	8.02	20.32	12.86	3.26	14.03	2.77	-1.17	0.88	
	Need	53.70	6.38	41.14	63.46	49.90	7.41	55.66	4.82	-5.76	1.73	**
	% Female	50.61	0.78	47.81	51.60	50.52	0.92	50.66	0.70	-0.14	0.23	
	Voter turnout by gender											
	Male	60.63	5.75	47.4	71.5	59.76	6.39	61.07	5.44	-1.31	1.72	
	Female	64.54	6.10	48.20	77.30	63.58	6.65	65.04	5.83	-1.46	1.83	
	% Female legislature	24.33	6.95	12.50	41	29.82	4.93	21.51	6.12	8.32	1.72	***
Race	Female poverty by race											
	White female	11.95	2.67	6.59	18.77	10.93	3.22	12.48	2.22	-1.55	0.77	+
	Black female	29.79	7.71	13.35	56.55	26.60	7.83	31.43	7.23	-4.82	2.22	*
	Need by race											
	White female	47.79	7.13	30.58	59.21	43.67	8.76	49.91	5.08	-6.24	1.95	**
	Black female	68.20	11.28	36.84	98.35	59.78	10.83	72.53	8.90	12.75	2.86	***
	% White	70.59	15.51	22.86	94.04	64.86	19.55	73.54	12.28	-8.67	4.51	+
	% Black	10.39	9.56	0.45	37.32	7.25	7.47	12.01	10.20	-4.76	2.80	+
	Voter turnout by race											
	White	64.74	5.35	48	75.20	65.28	6.02	64.46	5.04	0.82	1.61	
	Black+	61.52	10.24	30	82.4	59.70	10.95	62.46	9.91	-2.76	3.16	

+ N = 47; See text for details.

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

180

Table 4.2 Binary logistic regression of traditional variables on restrictive abortion coverage, 2014 (N = 50)

	Model 1		Model 2		Model 3a		Model 3b		Model 4	
	coef	se	coef	se	coef	se	coef	se	coef	se
GDP per capita	-49.2	(49.3)								
Gini coefficient	-4.57	(21.6)								
Unemployment rate	-0.31	(0.24)								
% under 18	0.41	(0.43)								
% 65 and older	0.18	(0.40)								
Poverty rate	0.11	(0.20)							-0.23	(0.19)
Unionization			-0.25 *	(0.11)					-0.28 *	(0.13)
Voter turnout			0.22	(0.15)						
Democratic gov't			-0.98 **	(0.35)					-0.62 *	(0.27)
Voter ID laws			0.45	(0.55)						
South			2.32	(1.43)						
Pre-Roe abortion law			-1.20	(0.92)						
% Evangelical					-0.01	(0.04)				
% Mainline Protestant					0.07	(0.08)				
% Catholic					-0.04	(0.06)				
Religiosity					4.69 +	(2.40)			1.45	(2.85)
Liberal political ideology							-0.08	(0.06)	-0.03	(0.05)
Support legal abortion							-0.04	(0.07)		
Pseudo r^2	0.151		0.558		0.203		0.286		0.475	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 4.3 Binary logistic regression of gender variables on restrictive abortion coverage, 2014 (N = 50)

	Model 1		Model 2a		Model 2b		Model 3	
	coef	se	coef	se	coef	se	coef	se
Unionization	-0.28 *	(0.12)	-0.32 **	(0.11)	-0.31 **	(0.11)	-0.29 *	(0.13)
Democratic gov't	-0.66 **	(0.24)	-0.74 **	(0.26)	-0.72 **	(0.26)	-0.70 *	(0.28)
Poverty by gender								
Male			-0.17	(0.17)				
Female					-0.11	(0.14)		
Need							-0.02	(0.07)
% Female								
Voter turnout by gender								
Male								
Female								
% Female legislature								
Pseudo r^2	0.442		0.460		0.451		0.443	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 4.3 *Continued*

	Model 4		Model 5a		Model 5b		Model 6	
	coef	se	coef	se	coef	se	coef	se
Unionization	-0.24 +	(0.13)	-0.27 *	(0.12)	-0.28 *	(0.11)	-0.24 +	(0.13)
Democratic gov't	-0.78 **	(0.28)	-0.72 **	(0.23)	-0.78 ***	(0.23)	-0.45	(0.35)
Poverty by gender								
Male								
Female								
Need								
% Female	0.65	(0.58)						
Voter turnout by gender								
Male			0.09	(0.06)	0.13	(0.08)		
Female								
% Female legislature							-0.14	(0.13)
Pseudo r^2	0.459		0.460		0.478		0.489	

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

Table 4.4 Binary logistic regression of race variables on restrictive abortion coverage, 2014 (N = 50)

	Model 1		Model 2		Model 3		Model 4[+]		Model 5	
	coef	se	coef	se	coef	se	coef	se	coef	se
Unionization	-0.28 *	(0.12)	-0.28 *	(0.12)	-0.28 +	(0.16)	-0.25 *	(0.11)	-0.28 *	(0.14)
Democratic gov't	-0.66 **	(0.24)	-0.62 *	(0.24)	-0.62 *	(0.31)	-0.77 **	(0.29)	-0.77 **	(0.26)
Female poverty by race										
White female			-0.07	(0.14)						
Black female			0.07	(0.05)						
Need by race										
White female					-0.14	(0.15)				
Black female					0.21	(0.16)				
% White							0.08 *	(0.04)		
% Black							0.14 +	(0.08)		
Voter turnout by race										
White									0.01	(0.07)
Black									0.08 +	(0.05)
Pseudo r^2		0.442		0.457		0.545		0.543		0.478

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

+ N = 47

Table 4.5 Calibrations for fuzzy set QCA

Type	Condition	Crisp set	Fuzzy set		
			Full membership	Cross-over point	Non-membership
Outcome	Restrictive abortion policy	1 = allows only those mandated by federal (or less) 0 = allows it for expanded circumstances			
Functional	High GDP per capita		0.075	0.063	0.03
	High Gini		0.48	0.45	0.42
	High unemployment		10	7.5	5
	Large young population		30	25	20
	Large old population		16	14	10
	High poverty		20	15	10
Power/Political	High unionization		20	16	10
	High voting percent		70	60	50
	Democratic regime	1 = D gov/D leg = 4 .6 = D gov/S leg or I gov/D leg = 3 .5 = D gov/R leg or I gov/S leg or R gov/D leg = 2 .4 = I gov/R leg or R gov/S leg = 1 0 = R gov/R leg = 0			
	Presence of voter ID laws	1 = strict photo = 4 .8 = strict non-photo = 3 .7 = non-strict photo = 2 .4 = non-strict non-photo = 1 0 = none = 0			
	South	1 = southern state 0 = not southern state			
	Pre-Roe abortion policy	1 = abortion legal prior to Roe 0 = abortion illegal prior to Roe			

185

Table 4.5 *Continued*

Type	Condition	Crisp set	Fuzzy set		
			Full membership	Cross-over point	Non-membership
Opinion	Liberal political ideology		75	50	25
	High support for legal abortion		60	50	20
	High importance of religion		2.5	2	1.75
	High percent Catholic		50	25	5
	High percent Evangelical		50	25	5
	High percent Protestant		50	25	5
Gender	High female poverty		20	15	10
	High male poverty		20	15	10
	High need for con.		61	53	43
	High female voting		70	60	50
	High male voting		70	60	50
	High female legislatures		35	30	20
Race	High White female poverty		20	15	10
	High Black female poverty		20	15	10
	High White need		61	53	43
	High Black need		61	53	43
	High White voting		70	60	50
	High Black voting		70	60	50

Table 4.6 Consistency and coverage scores for necessity for all conditions and their negations, by condition type

Type	Condition	Consistency	Coverage
Functional	GDP per capita	0.30	0.57
Functional	~ GDP per capita	0.70	0.71
Functional	Gini	0.62	0.65
Functional	~ Gini	0.38	0.68
Functional	Unemployment	0.62	0.63
Functional	~ Unemployment	0.38	0.72
Functional	Young	0.33	0.73
Functional	~ Young	0.67	0.63
Functional	Old	0.56	0.65
Functional	~ Old	0.44	0.67
Functional	Poverty	0.53	0.72
Functional	~ Poverty	0.47	0.60
Power/Political	Union	0.06	0.23
Power/Political	~ Union	0.94	0.76
Power/Political	Vote	0.65	0.69
Power/Political	~ Vote	0.35	0.61
Power/Political	Democratic	0.23	0.36
Power/Political	~ Democratic	0.77	0.88
Power/Political	Voter ID laws	0.53	0.85
Power/Political	~ Voter ID laws	0.47	0.53
Power/Political	South	0.39	0.81
Power/Political	~ South	0.61	0.59
Power/Political	Abortion legal Pre-Roe	0.33	0.55
Power/Political	~ Abortion legal pre-Roe	0.67	0.73
Power/Political	Evangelical	0.56	0.75
Power/Political	~ Evangelical	0.44	0.57
Power/Political	Catholic	0.28	0.55
Power/Political	~ Catholic	0.72	0.71
Power/Political	Protestant	0.26	0.70
Power/Political	~ Protestant	0.74	0.65
Power/Political	Religiosity	0.78	0.73
Power/Political	~ Religiosity	0.22	0.50
Power/Political	Liberal ideology	0.35	0.49
Power/Political	~ Liberal ideology	0.65	0.82
Power/Political	Support legal abortion	0.60	0.57
Power/Political	~ Support legal abortion	0.40	0.87

~ = Negation

Table 4.6 *Continued*

Type	Condition	Consistency	Coverage
Gender	Female poverty	0.64	0.72
Gender	~ Female poverty	0.36	0.57
Gender	Male poverty	0.41	0.72
Gender	~ Male poverty	0.59	0.62
Gender	Need	0.69	0.78
Gender	~ Need	0.31	0.49
Gender	Female population	0.57	0.69
Gender	~ Female population	0.43	0.62
Gender	Female vote	0.73	0.68
Gender	~ Female vote	0.27	0.61
Gender	Male vote	0.56	0.69
Gender	~ Male vote	0.44	0.63
Gender	Female legislature	0.15	0.35
Gender	~ Female legislature	0.85	0.79
Race	White female poverty	0.24	0.74
Race	~ White female poverty	0.76	0.64
Race	Black female poverty	0.99	0.68
Race	~ Black female poverty	0.01	0.17
Race	White need	0.31	0.66
Race	~ White need	0.69	0.66
Race	Black need	0.90	0.66
Race	~ Black need	0.10	0.68
Race	White population	0.60	0.73
Race	~ White population	0.40	0.58
Race	Black population	0.32	0.80
Race	~ Black population	0.68	0.61
Race	White vote	0.71	0.64
Race	~ White vote	0.29	0.70
Race	Black vote	0.61	0.67
Race	~ Black vote	0.41	0.35

~ = Negation

Table 4.7 Consistency and coverage scores for necessity for all conditions and their negations, by consistency

Type	Condition	Consistency	Coverage
Race	Black female poverty	0.99	0.68
Power/Political	~ Union	0.94	0.76
Race	Black need	0.90	0.66
Gender	~ Female legislature	0.85	0.79
Power/Political	Religiosity	0.78	0.73
Power/Political	~ Democratic	0.77	0.88
Race	~ White female poverty	0.76	0.64
Power/Political	~ Protestant	0.74	0.65
Gender	Female vote	0.73	0.68
Power/Political	~ Catholic	0.72	0.71
Race	White vote	0.71	0.64
Functional	~ GDP per capita	0.70	0.71
Gender	Need	0.69	0.78
Race	~ White need	0.69	0.66
Race	~ Black population	0.68	0.61
Power/Political	~ Abortion legal pre-Roe	0.67	0.73
Functional	~ Young	0.67	0.63
Power/Political	Vote	0.65	0.69
Power/Political	~ Liberal ideology	0.65	0.82
Gender	Female poverty	0.64	0.72
Functional	Unemployment	0.62	0.63
Functional	Gini	0.62	0.65
Race	Black vote	0.61	0.67
Power/Political	~ South	0.61	0.59
Power/Political	Support legal abortion	0.60	0.57
Race	White population	0.60	0.73
Gender	~ Male poverty	0.59	0.62
Gender	Female population	0.57	0.69
Power/Political	Evangelical	0.56	0.75
Functional	Old	0.56	0.65
Gender	Male vote	0.56	0.69
Functional	Poverty	0.53	0.72
Power/Political	Voter ID laws	0.53	0.85
Power/Political	~ Voter ID laws	0.47	0.53
Functional	~ Poverty	0.47	0.60
Gender	~ Male vote	0.44	0.63
Functional	~ Old	0.44	0.67
Power/Political	~ Evangelical	0.44	0.57

~ = Negation

Table 4.7 *Continued*

Type	Condition	Consistency	Coverage
Gender	~ Female population	0.43	0.62
Race	~ Black vote	0.41	0.35
Gender	Male poverty	0.41	0.72
Race	~ White population	0.40	0.58
Power/Political	~ Support legal abortion	0.40	0.87
Power/Political	South	0.39	0.81
Functional	~ Gini	0.38	0.68
Functional	~ Unemployment	0.38	0.72
Gender	~ Female poverty	0.36	0.57
Power/Political	Liberal ideology	0.35	0.49
Power/Political	~ Vote	0.35	0.61
Functional	Young	0.33	0.73
Power/Political	Abortion legal Pre-Roe	0.33	0.55
Race	Black population	0.32	0.80
Race	White need	0.31	0.66
Gender	~ Need	0.31	0.49
Functional	GDP per capita	0.30	0.57
Race	~ White vote	0.29	0.70
Power/Political	Catholic	0.28	0.55
Gender	~ Female vote	0.27	0.61
Power/Political	Protestant	0.26	0.70
Race	White female poverty	0.24	0.74
Power/Political	Democratic	0.23	0.36
Power/Political	~ Religiosity	0.22	0.50
Gender	Female legislature	0.15	0.35
Race	~ Black need	0.10	0.68
Power/Political	Union	0.06	0.23
Race	~ Black female poverty	0.01	0.17

~ = Negation

Table 4.8 Subset/superset analysis results, sorted by coverage[+]

Type	Recipe	Consistency for sufficiency	Coverage for sufficiency
Functional	~gdpfz*unempfz	0.71	0.55
	~gdpfz	0.71	0.70
	~gdpfz*ginifz	0.71	0.54
	~gdpfz*unempfz*ginifz	0.70	0.49
	~gdpfz*~youngfz*ginifz	0.69	0.48
	~gdpfz*~youngfz*unempfz	0.69	0.46
	~gdpfz*~youngfz*unempfz*ginifz	0.69	0.44
Power/Political	~unionfz	0.75	0.94
	relimpfz	0.73	0.78
	~unionfz*relimpfz	0.78	0.78
	~demfz	0.88	0.77
	~unionfz*~demfz	0.91	0.74
	relimpfz*~demfz	0.89	0.65
	~unionfz*relimpfz*~demfz	0.91	0.65
Gender	~legffz*needfz	0.85	0.67
	~legffz*povffz	0.81	0.63
	~legffz*needfz*povffz	0.84	0.59
	voteffz*needfz	0.80	0.56
	~legffz*voteffz*needfz	0.86	0.55
	~legffz*voteffz*povffz	0.82	0.50
	voteffz*needfz*povffz	0.80	0.49
	~legffz*voteffz*needfz*povffz	0.85	0.48
Race	povfbfz	0.68	0.99
	needbfz	0.66	0.90
	povfbfz*needbfz	0.68	0.90
	povfbfz*~povfwfz	0.66	0.76
	povfbfz*votewfz	0.67	0.72
	povfbfz*needbfz*~povfwfz	0.67	0.71
	povfbfz*needbfz*votewfz	0.66	0.66
	povfbfz*~povfwfz*votewfz	0.66	0.65
	povfbfz*needbfz*~povfwfz*votewfz	0.66	0.62

[+] Consistency cutoffs
   Functional: 0.69
   Power/Political: n/a
   Gender: 0.80
   Race: 0.66
   Combined: 0.93

Table 4.8 *Continued*[+]

Type	Recipe	Consistency for sufficiency	Coverage for sufficiency
Combined	povfbfz*~legffz*~demfz	0.93	0.70
	~unionfz*~legffz*~demfz	0.94	0.70
	~unionfz*povfbfz*~legffz*~demfz	0.94	0.69
	~unionfz*needbfz*~demfz	0.93	0.67
	~unionfz*needbfz*povfbfz*~demfz	0.93	0.67
	povfbfz*~legffz*relimpfz*~demfz	0.93	0.65
	~unionfz*~legffz*relimpfz*~demfz	0.94	0.65
	~unionfz*povfbfz*~legffz*relimpfz*~demfz	0.94	0.65
	~unionfz*needbfz*~legffz*~demfz	0.94	0.63
	~unionfz*needbfz*povfbfz*~legffz*~demfz	0.94	0.63
	~unionfz*needbfz*~legffz*relimpfz*~demfz	0.93	0.60
	~unionfz*needbfz*povfbfz*~legffz*relimpfz*~demfz	0.93	0.60

[+] Consistency cutoffs
   Functional: 0.69
   Power/Political: n/a
   Gender: 0.80
   Race: 0.66
   Combined: 0.93

Table 4.9 Truth table and solutions for combined conditions

Black female pov.	Union	Dem	Female leg.	Freq.	Consistency	Solution	Recipe	Coverage for sufficiency	Consistency for sufficiency
1	0	0	0	23	0.941	Complex	povbfz*~unionfz*~demfz*~legffz	0.689	0.941
1	0	1	0	7	0.510	Parsimonious	povbfz*~demfz*~legffz	0.704	0.933
1	0	1	1	7	0.364	Intermediate	povbfz*~unionfz*~demfz*~legffz	0.689	0.941
1	1	1	1	2	0.172				
1	0	0	1	1	0.584				
1	1	1	0	1	0.240				
0	1	0	1	1	0.056				
0	1	0	0	1	0.026				
0	0	0	0	0					
1	1	0	0	0					
0	0	1	0	0					
0	1	1	0	0					
0	0	0	1	0					
0	1	0	1	0					
1	1	0	1	0					
0	0	1	1	0					

Frequency cutoff: 1
Consistency cutoff: .9
Assumptions: Black female pov., ~ Unionization, ~ Female legislature, ~ Democratic

Table 4.10 Binary logistic regression of traditional variables on restrictive abortion coverage, 2014 (N = 50)

	coef		se
Membership in solution set	6.063	***	(1.60)
Pseudo r^2			0.490

Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10

CHAPTER 5

SUMMARY AND CONCLUSION

The exceptional status of the American healthcare system, particularly in regard to women's reproductive care, continues to puzzle academics and activists alike. In comparison with its industrialized peers, the United States continues to provide some of the worst forms of protection for women, while still maintaining one of the highest rates of female poverty (Orloff 1996). Importantly, these disadvantages are not equally distributed among women, with women of color bearing the brunt of this inequality, particularly in regard to reproductive healthcare services (Center for Reproductive Rights 2011; DuMonthier, Childers, and Milli 2017; Howell and Starrs 2017; Joffe and Parker 2012). As such, this project seeks to better understand how and why variation exists between U.S. states on their support of publicly funded reproductive healthcare. In doing so, I explore larger questions of the state's role in perpetuating or mitigating instances of inequality along lines of gender, race, and class.

In Chapter 1, I provided an outline of the theoretical and historical motivations for studying state variation in spending for reproductive healthcare. Drawing from conventional notions of welfare state development, I described how functional, alongside power and political, factors tend to shape the extent to which a state invests in social protections. Additionally, I highlighted how racialized and gendered social processes play out within the welfare state development process, and the importance of applying an intersectional lens to comparative welfare state studies. This is particularly true when considering spending for reproductive healthcare services. The history of family planning policy emphasizes the extent to which racial prejudices play out in both policy-making and implementation processes. We see the sustained

influence of racial prejudice today, when preventing access to affordable reproductive healthcare disproportionately hurts women of color experiencing poverty (Hasstedt 2017; Howell and Starrs 2017). As such, careful examination of the variation of support for reproductive healthcare between states is both timely and theoretically intriguing.

Chapter 2 set the stage for investigation into the question of how and why states vary in their support of publicly funded reproductive services. Specifically, it investigated variation in Medicaid spending between states, from 2006-2016. Overall, results supported the importance of functional factors, such as poverty status, but suggested that these factors were tempered somewhat by the race of those experiencing poverty. When spending generosity was operationalized by Medicaid spending per GDP, state policy appeared to be more reflective of the needs of White citizens. When operationalized as Medicaid spending per total social spending, however, the opposite was true; state policy was more reflective of the needs of Black citizens. This distinction importantly suggests the utility of more nuanced investigations into welfare state spending for healthcare in order to uncover why states that devote larger amounts of their spending budget to Medicaid are more responsive to Black poverty needs than states that devote larger amounts of their overall GDP.

Next, Chapter 3 narrowed the scope to spending for family planning services specifically, namely contraception and sterilization. Like in Chapter 2, the racialized nature of levels of poverty and need for publicly funded contraceptives within a state is apparent. Regardless of the operationalization of my outcome, White women's needs appeared to be more tightly associated with spending generosity than Black women's needs. Not only was there a difference in level of significance, but when Black women's needs were significantly associated with the outcome, they actually suggested a decrease in funding generosity.

196

Finally, in Chapter 4, I sought to investigate a particularly politically- and socially-charged reproductive policy, public funding for abortions. Given its historical status, I was curious as to whether political factors, including public opinion, might play a larger role in shaping policy decisions than in the previous two chapters. This indeed appeared to be the case, as level of unionization and Democratic political representation were dominantly featured in both the regression and qualitative comparative analysis (QCA) results. Based on regression results alone, poverty levels did not appear to be meaningfully associated with policy on public funding for abortions, countering the results from previous chapters. I also used this chapter to offer a comparison of different methods, regression and QCA, for evaluating variation in welfare state spending. Both the small number of cases within my data and my desire to apply a more intersectional framework to my study supported the application of QCA alongside more conventional regression methods. Indeed, results from the former appear much stronger than those of the latter, highlighting the importance of expanding the methodological tools available to comparative welfare state scholars. Furthermore, QCA results appear more similar to those from other chapters, in the extent to which they reveal racial processes at play in shaping policy response to need.

Together, the findings from each chapter successfully illustrate the continued relevance of incorporating race and gender into the welfare state literature. In particular, they emphasize the extent to which current policy perhaps serves to reproduce race, gender, and class inequalities rather than alleviate them. Previous scholarship recognizes the state's role in shaping and perpetuating our notions of race (Delgado and Stefancic 2012; Feagin 2013; HoSang, LaBennett, and Pulido 2012; Omi and Winant 1986) and gender (Acker 1990; Walby 1994), and future work

197

would benefit by continuing to explore the constellations of political processes at play in creating discriminatory public policy.

What will the future of healthcare look like? The debate over healthcare policy, what should be covered, and the role of the federal government in shaping state decision-making is far from new (Haeder and Weimer 2015). Recent calls for "Medicare-for-all" by, among others, 2020 Democratic presidential candidates (Uhrmacher et al. 2019) provide hope that we are seeing a shift in the political and public spaces that reframes healthcare as a national right rather than a privilege of the wealthy and/or gainfully employed. Still other politicians remain rigid in their insistence of the autonomous role of individuals, employees, and the marketplace in shaping health insurance decisions. While the current Republican-majority Congress continues calling for the repeal of the ACA (Davis 2019), their difficulty in doing so (Sullivan 2018), alongside the widening public support for universal healthcare (Kiley 2018), offers hope that healthcare, and particularly reproductive healthcare, as a right of citizenship may be taken more seriously in the near future.

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